DOCUMENT RESUME

ED 442 034 CG 030 073

TITLE	Workshop on Children and Domestic Abuse.
INSTITUTION	National Academy of Sciences - National Research Council, Washington, DC. Board on Children, Youth, and Families.
SPONS AGENCY	David and Lucile Packard Foundation, Los Altos, CA.
PUB DATE	2000-04-00
NOTE	99p.
PUB TYPE	Collected Works - Proceedings (021)
EDRS PRICE	MF01/PC04 Plus Postage.
DESCRIPTORS	Battered Women; *Child Abuse; Children; Counselors; Emotional Response; *Family Violence; Law Enforcement; Program Development; Program Evaluation; *Victims of Crime; Workshops
IDENTIFIERS	Policymakers

ABSTRACT

This workshop coordinates with the publication of a volume of "The Future of Children." The goal of the workshop is to bring together researchers, policymakers, health providers, and law enforcement to review available research literature on children and domestic violence. Topics that were addressed include prevalence and effect of exposure to domestic violence on children; systems-level responses to children; innovative program approaches and techniques for evaluating the programs; and laws and policies affecting children exposed to violence. The workshop manual contains the following sections: (1) Logistical Information; (2) Agenda; (3) Presenter Information; (4) Innovative Program Descriptions; (5) Background Readings (topics include child maltreatment and women abuse, problems associated with children witnessing violence, police and mental health professionals' responses to children and violence; and the London Family Court Clinic, a children's mental health clinic committed to advocacy of children and families involved in the justice system); and (6) Background on Board on Children, Youth, and Families. (Contains 96 references.) (JDM)

Reproductions supplied by EDRS are the best that can be made
from the original document.

ED 442 034

Board on
Children, Youth,
and Families

Workshop on Children and Domestic Abuse

April 10, 2000

National Research Council/Institute of Medicine
National Academy of Sciences
Washington, D.C.

CG 030073

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

W. M. Burns

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

BEST COPY AVAILABLE

THE NATIONAL ACADEMIES
Advisers to the Nation on Science, Engineering, and Medicine
National Academy of Sciences
National Academy of Engineering
Institute of Medicine
National Research Council

Institute of Medicine
Commission on Behavioral and Social Sciences and Education
Board on Children, Youth, and Families

MEMORANDUM

DATE: March 29, 2000

TO: Workshop Participants

FROM: Michele D. Kipke

SUBJECT: Workshop on Children and Domestic Abuse

Thank you for your interest and participation in the Board on Children, Youth, and Families' workshop entitled *Children and Domestic Abuse*. The workshop will be convened in the **Auditorium of the National Academy of Sciences' main building located at 2101 Constitution Avenue N.W. in Washington, D.C. on Monday, April 10, 2000, from 8:30 a.m. to 4:30 p.m.**

This activity is being coordinated with the recent publication of a volume of *The Future of Children* on children and domestic violence by the David and Lucile Packard Foundation. The workshop, convened with funding from The David and Lucile Packard Foundation, will bring together researchers, policy makers, health providers, law enforcement, and other key stakeholders to review available research literature on children and domestic violence. Workshop participants will address the following topics:

- the prevalence and effects of child exposure to domestic violence;
- systems-level responses to children exposed to domestic violence, including health care delivery services, the mental health system, child protective services, the legal system, and community-based efforts;
- innovative program approaches and techniques for evaluating programs; and
- laws and policies affecting children exposed to domestic violence and their families.

The overarching goal of this workshop is to review and synthesize the current knowledge base for each of these topics, discuss the implications of this knowledge with regard to policy and practice, and identify gaps in the current research and practice knowledge base.

This workshop is being convened under the auspices of the Board on Children, Youth, and Families. The Board was established in 1993 under the joint aegis of the Institute of Medicine

2101 Constitution Avenue, NW, Washington, DC 20418 *Telephone* (202) 334 2034 *Fax* (202) 334 3829 national-academies.org

and the National Research Council of the National Academy of Sciences to provide a focal point for authoritative, nonpartisan analysis of child, youth, and family issues relevant to policy decisions. The mission of the Board is to promote the application of interdisciplinary science to policy issues that affect the health and well-being of children, youth, and families. Through the Forum on Adolescence, the Board on Children, Youth, and Families synthesizes analyzes and evaluates scientific research on critical national issues that relate to youth and their families, and disseminate research and its policy and programmatic implications. For more information about the Board, see our website at www.national-academies.org/cbsse/bocyf.

A related Board activity is the Committee on the Training Needs of Health Professionals to Respond to Family Violence. At the request of Congress and with funding from the Centers for Disease Control and Prevention, this new committee will assess the training needs of health professionals with respect to the detection and referral of family violence and will issue a final report in May of 2001. You can learn more about this project at www4.nationalacademies.org/CBSSE/BOCYFWeb/HealthFV.nsf.

Enclosed within this briefing book is the workshop agenda, logistical information for the meeting, a roster of presenters and their bioparagraphs, descriptions of programs that will be presented during the panel entitled "Innovative Approaches to Designing and Evaluating Intervention Programs," and information about the Board on Children, Youth, and Families. A copy of *The Future of Children* issue on Domestic Violence and Children is also included. If you have any questions about this workshop, please contact Drusilla Barnes at 202-334-2034 or dbarnes@nas.edu.

I look forward to seeing you at this very important meeting!

CONTENTS

Logistical Information ..... Tab 1

Agenda ..... Tab 2

Presenter Information ..... Tab 3

- Presenter and staff contact information
- Presenter and staff bioparagraphs

Innovative Program Descriptions ..... Tab 4

Background Readings ..... Tab 5

Background on the Board on Children, Youth, and Families ..... Tab 6

Domestic Violence and Children, *The Future of Children* 9:3 (Winter 1999)

Participant List available at the workshop

Board on
Children, Youth,
and Families

INSTITUTE OF MEDICINE
and
NATIONAL RESEARCH COUNCIL
Committee on the Training Needs of Health Professionals to Respond to Family Violence

Workshop on Children and Domestic Abuse
April 10, 2000

Logistics

Date/Times/Locations	Monday, April 10, 8:30 a.m. - 4:30 p.m. Workshop on Children and Domestic Abuse National Academy of Sciences Building, Auditorium 2101 Constitution Avenue, N.W. Washington, D.C. 20418
Lodging	River Inn Hotel 924 Twenty-Fifth Street, N.W. Washington, D.C. 20418 Telephone (202) 337-7600
Meals	Continental breakfast will be provided at 8:30 a.m. in the Great Hall Lunch will be served in the Great Hall
Staff Contacts	Michele Kipke, Board Director Felicia Cohn, Study Director Drusilla Barnes, Senior Project Assistant Amy Gawad, Research Assistant
Contact Information	Board on Children, Youth, and Families National Research Council/Institute of Medicine 2101 Constitution Avenue, N.W., HA-156 Washington, D.C. 20418 Telephone (202) 334-2034 Fax (202) 334-3829
Web Address	national-academies.org/cbsse/bocyf

Board on
Children, Youth, and Families

Workshop on Children and Domestic Abuse

Committee on the Training Needs of Health Professionals to Respond to Family Violence

Institute of Medicine/National Research Council
National Academy of Sciences
2101 Constitution Avenue, Lecture Room
Washington, D.C.

April 10, 2000

AGENDA

8:30 a.m. – 9:00 a.m.
REGISTRATION AND CONTINENTAL BREAKFAST

9:00 a.m. – 9:30 a.m.
WELCOME, INTRODUCTIONS, AND PURPOSE OF THE WORKSHOP

Patricia King, Workshop Chair & Professor of Law, Georgetown University

Michele Kipke, Director, Board on Children, Youth, and Families

9:30 a.m. – 10:30 a.m.
WHAT CAN WE DO TO ENSURE THE SAFETY, SECURITY, AND WELL-BEING OF CHILDREN AND HOW CAN WE PREVENT CHILDREN FROM BEING EXPOSED TO DOMESTIC VIOLENCE?

Jeremy Travis, Director, National Institute of Justice, U.S. Department of Justice
Carol Williams, Visiting Professor, School of Social Work, University of Pennsylvania
Lucy Salcido Carter, The David and Lucile Packard Foundation

Q&A and General Discussion

10:30 a.m. – 11:30 a.m.

RESEARCH ON THE PREVALENCE AND EFFECTS OF CHILD EXPOSURE TO DOMESTIC VIOLENCE

John Fantuzzo, Professor of Education, University of Pennsylvania
Ross Thompson, Distinguished Professor, Department of Psychology, University of Nebraska
Ernest Jouriles, Associate Professor, Department of Psychology, University of Houston

Moderator: **Jeffrey Edleson**, Professor, University of Minnesota

Q&A and General Discussion

1. What do we know about the prevalence of child exposure to domestic violence? What are the sources of the data, and the strengths and limitations of these data sources?
2. What is the impact of exposure to domestic violence on children? What are the implications for their development? Are there developmental differences?
3. What are the emotional and behavioral effects of exposure to domestic abuse?
4. What do we know about child resilience as a protective or buffering factor?
5. What are other risks and protective or buffering influences?
6. How can we disentangle the incidence and effects of exposure to domestic violence vs. actual abuse? Does exposure to domestic violence constitute abuse? Should it be considered as such?
7. Should exposure to violence be perceived as a gateway to service, or do the needs of children who are exposed to violence justify unique services?
8. What are the strengths and limitations of current research and the scientific knowledge-base? What gaps exist and what new research is needed?

11:30 a.m. – 12:30 p.m.

HOW ARE WE AND HOW SHOULD WE BE RESPONDING TO CHILDREN'S EXPOSURE TO DOMESTIC VIOLENCE?

Judge Cindy S. Lederman, Administrative Judge, Juvenile Division, Juvenile Justice Center, Miami, FL
Pamela L. Whitney, Director, Domestic Violence and Family Support, Massachusetts Department of Social Services
Elaine Alpert, Associate Professor of Public Health and Medicine, Boston University School of Medicine

Moderator: **Peter Jaffe**

Q&A and General Discussion

1. What laws and policies are being enacted to address the needs of children exposed to domestic violence and their families?
2. How are communities, law enforcement, social services, and the health care delivery system mobilizing to address the needs of children exposed to domestic violence and their families?
3. What are the intended goals and outcomes for these efforts, and what do we know about the effectiveness of these interventions?
4. What are the gaps and what new research is needed to advance these efforts?
5. What are the measurement issues, and how should we be measuring family functioning?
6. Are there unintended consequences of some of the policies that are being established?
7. How should we be thinking about issues of confidentiality?

12:30 p.m. – 1:15 p.m.
QUICK LUNCH

1:15 p.m. – 2:45 p.m.
INNOVATIVE APPROACHES TO DESIGNING & EVALUATING INTERVENTION PROGRAMS

Mental health in a health care setting- Betsy McAlister Groves, Assistant Professor of Pediatrics, Boston University School of Medicine
Community policing and child development – Steven Berkowitz, Coordinator, Child Development and Community Policing Program, Yale University
School based prevention/youth – David Wolfe, Professor, Department of Psychology and Psychiatry, University of Western Ontario
Program targeted to batterers – Oliver Williams, Associate Professor, School of Social Work, University of Minnesota

Moderator: **Joel Greenhouse**, Professor of Statistics, Carnegie Mellon University

Q&A and General Discussion

1. What are the goals of your programs?
2. When are your services provided, where are they delivered, and to whom are they targeted?
3. How, if at all, are your services integrated into other family or community services?
4. How does your program work with or relate to law enforcement?
5. How does your program work with or relate to the public health or health care delivery system?
6. How do you define high quality intervention services?
7. What are the challenges of generalizability, replication, and sustainability?
8. What training and credentialing is required of your staff?
9. How is your program being evaluated? What are the intended outcomes and how are you measuring this? What are the strengths and limitations of your evaluation plan? How could your evaluation be improved?

2:45 p.m. – 3:45 p.m.
RESEARCH, EVALUATION AND PROGRAM EFFECTIVENESS

Cris Sullivan, Associate Professor, Ecological Psychology, Michigan State University
Sandra Graham-Bermann, Associate Professor of Psychology and Woman's Studies Program, University of Michigan

Q&A and General Discussion

1. What are the intended and desired outcomes for intervention programs, and what are the strengths and limitations of existing indicators and data sources commonly used to evaluate and monitor the success of these programs?
2. What are the strengths and limitations of methods typically used to evaluate these programs?
3. How well do these intervention approaches meet the needs of children, families, and communities?
4. What gaps remain and what research is needed in the future?

3:45 p.m. – 4:30 p.m.
BRIDGING RESEARCH, POLICY, AND PRACTICE

Jeffrey L. Edleson, Professor, University of Minnesota
David Kolko, Associate Professor of Child Psychiatry and Psychology, University of Pittsburgh School of Medicine; Director, Special Services Unit, Western Psychiatric Institute and Clinic

Q&A and General Discussion

1. What are the costs and benefits of domestic violence intervention and prevention programs?
2. What should the next generation of domestic violence service and prevention look like?
3. Is there a body of research that is not being applied to this field?
4. Are there programs that are not being evaluated, and what is the right standard for evaluating these kinds of programs?
5. How should we be thinking about linking research, policy, and practice?

4:30 p.m.
CONCLUDING REMARKS

Patricia King

4:45 p.m.
ADJOURN

Board on
Children, Youth, and Families

Workshop on Children and Domestic Abuse

Committee on the Training Needs of Health Professionals to Respond to Family Violence

Institute of Medicine/ National Research Council
National Academy of Sciences
2101 Constitution Avenue, Lecture Room
Washington, D.C.

April 10, 2000

PRESENTER LIST

Elaine Alpert
Associate Professor of Public Heatlh and Medicine
Boston University
715 Albany Street, T-2W
Boston, MA 02118-2526
617-638-4118
617-638-4483 (fax)
ealpert@bu.edu

Steven Berkowitz
Coordinator,
Child Development and Community Policing Program
Yale Child Studies Center
Yale University
230 South Frontage Road
New Haven, CT 06520
203-737-1951
203-785-4608 (fax)
steven.berkowitz@yale.edu

Jeffrey L. Edleson
Professor
University of Minnesota
School of Social Work
386 McNeal Hall
1985 Buford Avenue
St. Paul, MN 55108-6142
612-624-8795
612-626-0395 (fax)

Sandra Graham-Bermann
Associate Professor of Psychology and Woman's Studies Program
University of Michigan
525 E. University Avenue
Ann Arbor, MI 48109-1109
734-763-3159
734-615-0573 (fax)
sandragb@umich.edu

Betsy McAlister Groves
Child Witness to Violence Project
Boston Medical Center
91 East Concord Street, 5th Floor
Boston, MA 02116
617-414-4244
617-414-7915 (fax)
bmcagroves@aol.com

Peter G. Jaffe
Executive Director
London Family Court Clinic, Inc.
254 Pall Mall Street, Suite 200
London, Ontario N6A SP6
Canada
519-679-7250, ext. 109
519-675-7772 (fax)
peter@lfcc.on.ca

John W. Fantuzzo
Diana Riklis Professor
University of Pennsylvania
Graduate School of Education
3700 Walnut Street
Philadelphia, PA 19104-6216
215-898-4790
215-573-2115 (fax)
johnf@gse.upenn.edu

Joel Greenhouse
Professor of Statistics
Carnegie Mellon University
500 Forbes Avenue
Pittsburgh, PA 15213
412-268-8872
412-268-7828 (fax)
joel@stat.cmu.edu

Ernest Jouriles
Associate Professor
Department of Psychology
University of Houston
4800 Calhoun Road
Houston, TX 77204-5341
713-743-8601
713-743-8633 (fax)
ejouriles@uh.edu

Patricia King
Professor of Law
Georgetown University Law Center
600 New Jersey Avenue, NW
Washington, DC 20024
202-662-9085
202-662-9495 (fax)

Michele Kipke
Director
Board on Children, Youth, and Families
National Research Council
2101 Constitution Avenue, NW, HA-156
Washington, DC 20418
202-334-1937
202-334-3829 (fax)
mkipke@nas.edu

David Kolko
Associate Professor
Department of Child Psychiatry and Psychology
Director, Child and Parent Behavior Clinic
University of Pittsburgh Medical Center &
Western Psychiatric Institute and Clinic
3811 O'Hara Street
Pittsburgh, PA 15213
412-624-2096
412-624-9081 (fax)
kolkodj@msx.upmc.edu

Judge Cindy S. Lederman,
Administrative Judge
Juvenile Division
Juvenile Justice Center
3300 N.W. 27th Avenue, Room 201
Miami, FL 33142
305-638-6087
305-634-9921 (fax)
judgeled@juno.com

Lucy Salcido Carter
Program Officer
The David and Lucile Packard Foundation
300 2nd Street, Suite 200
Los Altos, CA 94022
650-948-7658
650-941-2273/2481 (fax)
l.carter@packfound.org

Cris Sullivan
Associate Professor
Ecological Psychology
Michigan State University
E. Lansing, MI 48824-1117
517-353-8867
517-432-2945 (fax)
sulliv22@msu.edu

Ross A. Thompson
Professor
Department of Psychology
University of Nebraska
238 Burnett Hall
Lincoln, NE 68588-0308
402-472-3187
402-472-4637 (fax)
rthompson1@unl.edu

Jeremy Travis
Director
National Institute of Justice
U.S. Department of Justice
810 7th Street, NW. Rpp, 7422
Washington, DC 20531
202-307-2942
202-307-6394 (fax)
travisj@ojp.usdoj.gov

Carol Williams
Visiting Professor
School of Social Work
University of Pennsylvania
Associate Commissioner
Children's Bureau
U.S. Department of Health and Human Services
3701 Locust Walk
Philadelphia, PA 19104
215-898-5512
215-898-7301 (fax)

Oliver Williams
Associate Professor
School of Social Work
1404 Gortner Avenue
Room 105 PetersH
St. Paul, MN 55108
612-624-9217
owilliam@maroon.tc.umn.edu

Pamela L. Whitney
Director
Domestic Violence and Family Support
Massachusetts Department of Social Services
24 Farnsworth Street
Boston, MA 02476
617-748-2338
617-748-2441 (fax)
pwhitney@state.ma.us

David Wolfe
Professor
Department of Psychology
University of Western Ontario
London, Ontario N6A 5C2
Canada
(519) 661-3683
(519) 661-3961 (fax)
dawolfe@julian.uwo.ca

Staff

Michele Kipke, Director
Board on Children, Youth, and Families
mkipke@nas.edu

Felicia Cohn, Study Director
Committee on Training Needs of Health
Professionals to Respond to Family Violence
fcohn@nas.edu

Drusilla Barnes, Senior Project Assistant
Committee on Training Needs of Health
Professionals to Respond to Family Violence
dbarnes@nas.edu

Amy Gawad, Research Assistant
Committee on Training Needs of Health
Professionals to Respond to Family Violence
agawad@nas.edu

Scholar-in-Residence

Elena Nightingale, Advisor
Board on Children, Youth, and Families
enightin@nas.edu

Office location:

Committee on Training Needs of Health
Professionals
to Respond to Family Violence
Board on Children, Youth, and Families
National Research Council
2101 Constitution Avenue, NW
Washington, D.C. 20418
Telephone: (202) 334-2034
Fax: (202) 334-3829

Elaine J. Alpert has been on the faculty of Boston University School of Medicine since 1984 and is currently the assistant dean for student affairs in the School of Medicine and an associate professor of public health and medicine. Dr. Alpert has been active for several years in health professional education and community outreach in the area of family violence. She spearheaded the development of a model curriculum on family violence for Boston University School of Medicine, and has created a comprehensive post-graduate curriculum on domestic violence in collaboration with the Massachusetts Medical Society. She is also a faculty trainer for the Family Violence Prevention Fund. Dr. Alpert serves on numerous state and national advisory panels concerned with the health professions' response to family violence, and has spoken extensively to physicians, other health professions groups, and community organizations, about the role of health care professionals in responding to and preventing family violence and abuse.

Steven Berkowitz, MD

Dr. Steven Berkowitz is an assistant professor of Child and Adolescent Psychiatry at the Yale University, Child Study Center. He serves as the medical director of the Child Development-Community Policing Program, a collaboration between the New Haven Police Department and the Child Study Center to intervene with children and families exposed to violence. He also serves as co-medical director of the Yale Intensive In-home Child and Adolescent Psychiatry Service, which is a program for psychiatrically disturbed children and their families. Dr. Berkowitz has published articles concerning both these programs and on interventions for disadvantaged and traumatized children. His research interests include childhood trauma and its outcomes and particularly the relationship between child maltreatment and later aggressivity.

***Lucy Salcido Carter**, J.D. has* worked for The David & Lucile Packard Foundation since 1992 and is currently a Program Officer in the Children, Families, and Communities division. She handles the grant-making in the child protection area, which includes projects that address the co-occurrence of child maltreatment and childhood exposure to domestic violence. She edited the newly released issue of *The Future of Children* journal on domestic violence and children, and has also edited articles for the Juvenile Court, Sexual Abuse of Children, and Children and Poverty issues of the journal. Ms. Carter's previous employment includes work in the family and dependency law fields, and as a counselor in an alternative education program for inner city youth.

BIOGRAPHICAL INFORMATION: Jeffrey L. Edleson

Jeffrey L. Edleson is a Professor in the University of Minnesota School of Social Work and Director of the Minnesota Center Against Violence and Abuse (www.mincava.umn.edu). He has published over 80 articles and seven books on domestic violence, groupwork, and program evaluation. Dr. Edleson has conducted intervention research at the Domestic Abuse Project in Minneapolis for over 16 years. He has provided technical assistance to domestic violence programs and research projects across North America as well as in several other countries including Germany, Australia, Israel and Singapore.

He was a member of the National Research Council's Panel on Research on Violence Against Women. He currently sits on the Expert Panel of the National Resource Center on Domestic Violence, Child Protection, and Custody, a program of the National Council of Juvenile and Family Court Judges and is a consultant to the U.S. Centers for Disease Control and Prevention's Family and Intimate Violence Prevention Subcommittee.

Dr. Edleson is an Associate Editor of the journal Violence Against Women and has served on the editorial boards of the Journal of Interpersonal Violence, Journal of Family Violence, Aggression and Violent Behavior and Violence UpDate. He is Co-Editor of the Sage Book Series on Violence Against Women. His own books include Working with Children and Adolescents in Groups, co-authored with Sheldon D. Rose (1987, Jossey-Bass), Intervention for Men who Batter: An Ecological Approach, co-authored with Richard M. Tolman (1992, Sage Publications), Ending the Cycle of Violence: Community Responses to Children of Battered Women, co-edited with Einat Peled and Peter G. Jaffe (1995, Sage Publications), Future Interventions with Battered Women and Their Families, co-edited with Zvi Eisikovits (1996, Sage Publications), Evaluating Domestic Violence Programs (1997, Domestic Abuse Project), and Effective Intervention in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice (1999, co-authored with Susan Schechter, National Council of Juvenile & Family Court Judges). His most recent books are entitled Intimate Violence in the Lives of Children: The Future of Research, Intervention, and Social Policy (forthcoming 2000, co-edited with Sandra Graham-Bermann, American Psychological Association Books) and Sourcebook on Violence Against Women (forthcoming 2000, co-edited with Claire Renzetti and Raquel Kennedy Bergen, Sage Publications).

He is a Phi Beta Kappa graduate of the University of California at Berkeley and received his Masters and Ph.D. in Social Work from the University of Wisconsin at Madison. He is a Licensed Independent Clinical Social Worker in Minnesota and has practiced in elementary and secondary schools and in several domestic violence agencies.

Contact information:
MINCAVA
105 Peters Hall
1404 Gortner Avenue
St. Paul, MN 55108
tel (612) 624-8795
fax (612) 625-4288
email jedleson@tc.umn.edu

SANDRA A. GRAHAM-BERMANN, PH.D

Sandra A. Graham-Bermann, Ph.D., is Associate Professor in the Department of Psychology and Women's Studies Program at the University of Michigan. She has studied the impact of family violence on children's social and emotional adjustment and the efficacy of group treatments for the children of batterers. With funding from NIJ, CDC, and Administration for Children, Youth and Families, she has studied multiple forms of violence in the Lives of children using a nested ecological framework and social-cognitive and trauma theories. In order to study processes that mediate the link between children's reactions to violence and their adjustment, she has developed measures of childrens fears and worries, family stereotyping, sibling relationships, and traumatic stress in children. She is clinical consultant to local domestic violence programs and Head Start schools, and research consultant to the U S Department of Justice. In addition to authoring research journal articles, she has written Violence in the lives of American Children, for the Office of Juvenile Justice and Delinquency Prevention, Department of Justice, Washington, DC, and is co-editor (with Jeff Edleson, Ph.D.) of Intimate violence in the lives of children: The future of research, intervention, and policy (in press). Washington, DC: American Psychological Association Books.

Brief Biographical Statement

John W. Fantuzzo is the Diana Riklis Professor of Education in the Psychology of Education Division of the Graduate School of Education at University of Pennsylvania. He is a clinical child psychologist and a faculty member in APA-Approved School, Community, and Clinical Child Psychology Program at Penn. His research has focused primarily on the design, implementation, and evaluation of school- and community-based assessment and prevention strategies for vulnerable, low-income children and families in high-risk urban environments. His work places a special emphasis on identifying and cultivating the natural resources of peer and family systems for young children entering school (preschool, kindergarten, and first grade). His applied research is the result of numerous successful partnerships with parents, teachers, community leaders, and school administrators. Currently, Dr. Fantuzzo is working on two large-scale research projects with Dante Cicchetti investigating the impact of exposure to community and family violence on the developmental outcomes of urban Head Start children. This partnership effort includes collaborations among the Office of Early Childhood in the School District of Philadelphia, Children's Protective Services, and the Domestic Violence and Victim Assistance Units of the Philadelphia Police Department, and the Department of Public Health. Additionally he is working with the Office of Early Childhood in the School District of Philadelphia, which serves over 25,000 children to develop system-wide assessment of child development and parental involvement to identify vulnerable children and families to inform educational and special needs services.

Joel B. Greenhouse, Ph.D., is Professor of Statistics and Associate Dean of the College of Humanities and Social Sciences at Carnegie Mellon University, and Adjunct Professor of Psychiatry at the University of Pittsburgh. He is a Fellow of the American Statistical Association and of the American Association for the Advancement of Science, and an elected Member of the International Statistical Institute. Professor Greenhouse has been a member of the National Academy of Science's Committee on National Statistics, the Institute of Medicine's Committee on the Assessment of Family Violence Interventions, and the National Research Council panel on Statistical Issues for Research in the Combination of Information. His research interests include methods for the analysis of data from longitudinal and observational studies, and methods for clinical trials and meta-analysis. He has a B.S. from the University of Maryland, and Ph.D., M.P.H. and M.A. degrees from the University of Michigan.

BIOGRAPHICAL STATEMENT

BETSY McALISTER GROVES
Child Witness to Violence Project
Division of Developmental and Behavioral Pediatrics
Boston Medical Center
(617) 414-4244

Betsy McAlister Groves, MSW, LICSW is the founding Director of the Child Witness to Violence Project at Boston Medical Center, and Associate Professor of Pediatrics at Boston University School of Medicine. She is the recipient of a fellowship from the Open Society Institute and is currently on leave at the Kennedy School of Government at Harvard University. She has lectured widely, providing training to police, social workers, health providers, judges and court personnel, and teachers on a range of topics associated with children and violence. Publications include articles in the Journal of the American Medical Association, Pediatrics, Harvard Mental Health Letter, and Topics in Early Childhood Special Education. She is a member of the Mass. Governor's Commission on domestic violence and has served as consultant to Mass. Department of Social Services, the Massachusetts Judicial Institute, and Family Communications, Inc, producers of Mister Roger's Neighborhood.

Ms. Groves received her Master's degree from Boston University School of Social Work and her undergraduate degree from the College of William and Mary.

PETER JAFFE, PhD, C. Psych.

Dr. Jaffe is presently the Director of the London Family Court Clinic, which is a children's mental health centre specializing in issues which bring children and families into the justice system. He is a member of the Clinical Adjunct Faculty for the Department of Psychology and Professor (Part time) for the Department of Psychiatry at the University of Western Ontario.

He received his undergraduate training from McGill University in Montreal (1970) and his Ph.D. in Clinical Psychology from the University of Western Ontario (1974). Most of his clinical work and research involves children and adolescents involved with police or the courts, either as delinquents or victims of family violence or custody disputes as well as individuals traumatized by violence in childhood or adult relationships.

Dr. Jaffe was the founding Chairperson of the London Co-ordinating Committee to End Woman Abuse and is currently actively involved in research on the impact of family violence on children. He has also been instrumental in the foundation of the Battered Women's Advocacy Clinic and is a former chairperson of their Board of Directors. He has served on various community advisory committees for the London Police Service.

Dr. Jaffe has been a trustee for the London Board of Education (now the Thames Valley District School Board) since 1980. In 1987/88 he served one term as Chairperson. Dr. Jaffe has provided leadership in the development of violence prevention programs within the school system. In December 1999, he was re-elected Chairperson of the newly amalgamated Thames Valley District School Board for a second term.

Between 1991 and 1993, Dr. Jaffe, was a member of the Canadian Panel on Violence Against Women. This federally appointed committee examined the issue of violence against women through meetings in 139 communities across Canada, encouraging individuals, community groups and professional associations, to identify solutions from their perspective. The final report heightened public awareness of the problem and outlined prevention strategies to end violence.

Dr. Jaffe was honoured by receiving the Commemorative Medal for the 125th Anniversary of the Confederation of Canada for his dedication and contributions to the community and to all fellow Canadians.

In April 1994, Dr. Jaffe was awarded the distinguished Colonel Watson Award, presented annually by the Ontario Association for Curriculum Development, for his significant contribution to education in Ontario.

In 1995, Dr. Jaffe was appointed as Chairperson of the Board of Directors for the Centre for Research on Violence Against Women and Children.

In December 1998, Dr. Jaffe was appointed to the Joint Steering Committee on Domestic Violence Prevention, to provide advice to the Attorney General on the implementation of the jury's recommendations from the May/Iles Inquest.

1999 12 23

BEST COPY AVAILABLE

Ernest N. Jouriles is professor of psychology at the University of Houston. He received his B.A. from Indiana University at Bloomington and his Ph.D. from the State University of New York at Stony Brook. Since earning his degree in clinical psychology, he has been on the faculty at the University of Houston. His research interests center around understanding and ameliorating the negative effects of marital conflict and violence on children. He has published numerous scientific articles in the areas of marital conflict and child adjustment, domestic violence, and child maltreatment. His research has been supported by grants from the National Institute of Mental Health, the Interagency Consortium on Violence Against Women and Violence in the Family Research, the National Institute of Justice, the Texas Higher Education Coordinating Board, the George Foundation, and the Hogg Foundation for Mental Health. Dr. Jouriles received an early career award from the Association for Advancement of Behavior Therapy for his research on marital and child problems.

Patricia A. King

Carmack Waterhouse Professor of Law, Medicine, Ethics, and Public Policy;
Director, Center for Applied Legal Studies
B.A., Wheaton College; J.D., Harvard

Professor King's expertise is in the study of law, medicine, ethics and public policy. She is also an adjunct professor in the Department of Health Policy and Management, School of Hygiene and Public Health at Johns Hopkins University. She teaches Family Law and Torts and offers a seminar in Law, Medicine and Ethics and is the co-author of Cases and Materials on Law, Science and Medicine. She is a member of the American Law Institute and the Institute of Medicine, a Fellow of the Hastings Center, and a Senior Research Scholar at the Kennedy Institute of Ethics. Her work in the field of bioethics has included service on the HEW-Advisory Recombinant DNA Advisory Committee; the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research; the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research; and the Ethics, Legal and Social Issues Working Group of the Human Genome Project. She is a board member of the Hospice Foundation, the National Partnership of Women and Families, and Vice Chair of the Board of Trustees of Wheaton College. She is also active with medical and health professional organizations and currently on the Board of Advisors to the American Board of Internal Medicine and the Board of Henry J. Kaiser Family Foundation. Her professional experience before joining the Law Center faculty in 1973 was primarily in the civil rights field; she was the Deputy Director of the Office of Civil Rights and Special Assistant to the Chairman of the EEOC. She also served as a Deputy Assistant Attorney General in the Civil Division of the Department of Justice. Professor King previously served as Chair of the Institute of Medicine's Committee on Assessment of Family Violence Interventions and now serves on Council of the Institute of Medicine.

JUDGE CINDY S. LEDERMAN
Juvenile Justice Center
3300 N.W. 27th Avenue
Room 201
Miami, Fl. 33142
(305) 638-6087
(305) 638-6042 fax

Judge Cindy S. Lederman received a Bachelor of Arts in 1976 with high honors from the University of Florida, received her Juris Doctor in 1979 at the University of Miami School of Law and was admitted to practice law in Florida and New York. Judge Lederman was a trial lawyer in private practice until 1982 and thereafter served as Deputy City Attorney for the City of North Miami Beach until her elevation to the bench.

Judge Lederman was elected to the County Court in Dade County in 1988 and was appointed to the Circuit Court of the Eleventh Judicial Circuit by Governor Chiles on July 15, 1994, where she serves in the Juvenile Division as Administrative Judge. Prior to her elevation, Cindy S. Lederman was the Administrative Judge of the Domestic Violence Court of the Eleventh Judicial Circuit in Dade County, Florida. Dade County's innovative Domestic Violence Court is one of the most comprehensive domestic violence initiatives in any criminal justice system in the United States. Judge Lederman was a leader of the team that created the Court.

While serving in the juvenile division, Judge Lederman's efforts have resulted in the award of two grants relating to her work in the field of child maltreatment. She is a U.S. Department of Justice grant recipient and co-author of the Dependency Court Intervention Program for Family Violence, a national demonstration project involving the co-occurrence of child maltreatment and family violence, funded by the Office of Justice Programs, and a grant recipient and author of a concept that has become a project entitled, "Judicial Decisionmaking to Ensure Permanency Planning for Substance Exposed Newborns", funded by the State Justice Institute.

Judge Lederman is a member of the Board on Children, Youth and Families of the National Research Council, has been a faculty member of the National Judicial College since 1992 and was the course coordinator and lead faculty of the National Judicial College's Domestic Violence Course, former President of the National Association of Women Judges. Judge Lederman presently is a member of the American Bar Association House of Delegates, the Board of Directors of the Voices for Children Foundation, the Board of Directors of Kristi House and served on the Board of Directors of the Mental Health Association of Dade County, the Inner City Children's Dance Company, Board of Directors of the P.A.C.E. Center for Girls, and currently serves on the Community Advisory Board for the Junior League of Miami. Judge Lederman serves on the Florida Supreme Court Commission on Fairness and served as a Commissioner on the Florida Supreme Court Race and Ethnic Bias Study Commission and was a Commissioner on the Florida Supreme Court Gender Bias Implementation Commission. Prior to becoming a judge, she worked in the private and public section as a trial lawyer and served as Vice-chair of the Dade County Commission on the Status of Women and President of the Dade County Chapter of the Florida Association of Women Lawyers.

Judge Lederman teaches and lectures, both locally and nationally on domestic violence. In

BEST COPY AVAILABLE

1994, she was selected to serve on the National Academy of Sciences National Research Council Committee on Family Violence Interventions and in 1998, she was appointed as liaison to the National Research Council Panel on Juvenile Crime.

In May 1994, she represented the United States Judiciary on an eight day lecture tour in Italy for the United States Information Agency.

Judge Lederman was invited to be a member of a 7 person international family violence consulting team to the Chinese Women Judges' Association in Beijing, China from April 25-29, in preparation for the United Nations Conference on Women held in Beijing in September, 1995. In May 1997, Judge Lederman returned to China to participate in a Symposium on Judicial Protection of Women's Rights.

In July 1995, Judge Lederman was appointed by the U.S. Attorney General Janet Reno and Health and Human Services Secretary Donna Shalala to the new Federal Advisory Council on Violence Against Women.

On April 15, 1997, Governor Lawton Chiles awarded Judge Lederman the Governor's Peace at Home Award in recognition of her work in the field of Domestic Violence.

In 1999, Judge Lederman was awarded a Fellowship from Zero to Three: The National Center for Infants, Toddlers and Families.

On August 24, 1999, Judge Lederman received The William E. Gladstone Award, the state's highest honor for children's advocacy.

BEST COPY AVAILABLE

Brief Biographical Sketch

David J. Kolko, Ph.D.
Associate Professor of Child Psychiatry and Psychology
Director, WPIC Special Services Unit

Academic and Professional Career

I maintain a strong clinical-research interest in children/youth as victims and/or perpetrators of violence. Specifically, I have pursued providing and studying services related to family violence, particularly child physical abuse, and child antisocial/disruptive behavior (e.g., conduct disorder, firesetting). Most recently, I have established collaboration with the Juvenile Court to develop and evaluate services for adjudicated youth, such as adolescent sexual offenders and firesetters. The populations in which I am interested generally consist of children with severe conduct/behavior problems who live with dysfunctional parents in disrupted, coercive families.

I am very committed to developing comprehensive assessment and clinical treatment services for youth within the child protective services and juvenile justice systems. Two years ago, I organized a specialized clinical-research program (The Special Services Unit) designed to treat and study disruptive/delinquent youth and their families after receiving a grant (funded by the Pennsylvania Commission on Crime and Delinquency) to collaborate with probation officers from the Juvenile Court in providing comprehensive mental health treatment and Wraparound services to juvenile sexual offenders and their families. I worked closely with several administrative and clinical staff over the past year to develop this sex offender program from the ground up, which included its treatment, research, and legal underpinnings (e.g., division administration, medical records, legal counsel, outpatient patient registration, liaison to the Court/Judges).

My newest clinical activities have taken place in the context of serving as the Consulting Psychologist/Clinical Supervisor for the Family Intervention Center at Children's Hospital, which is their child abuse investigation team. I was selected for this role because of my prior clinical and research work dealing with both physical and sexual abuse. For the past six months, I have provided leadership, clinical input, and programmatic recommendations to both clinical staff and the two co-directors of this service as we attempt to revise and expand the program.

I remain very committed to pursuing academic projects that evaluate the course and outcome of intervention, treatment effectiveness, and innovative collaborative community-based interventions to address refractory problems. A short list of some recent grants appears below. The most relevant ones include my current Child ODD/CD treatment effectiveness study (NIMH), a recently completed outcome study for child firesetting (NIMH), a CPS service delivery study (NCCAN), an outcome study for child physical abuse (NCCAN), and an outcome study for depressed adolescents (NIMH). My presentations at state and national meetings focus upon intervention and service delivery (e.g., AABT, APSAC, NAS, NIJ, NIMH, Oregon State Fire Marshall).

I was recently re-elected to a second term as a member of the Board of Directors of the American Professional Society for the Abuse of Children (APSAC), a national organization of >5,000 professionals working in this country and Canada. I have also been invited to extend my tenure as Chair of its Research Committee

Selected Grant Projects

CDP: #2239	Interventions for Aggressive, Physically Abuse Children Principal Investigator	1991-1994	NCCAN (DHHS)

MH-39976-06	Interventions for Child Firesetters: A Clinical Trial Principal Investigator	1991-1995	NIMH
MH-46500	Depressed Adolescent Suicide Attempters: A Clinical Trial. Co-Princ. Investigator (David Brent, M.D., PI)	1991-1995	NIMH
	Service Use, Obstacles, and Outcomes in Children With Antisocial Behaviors - Principal Investigator	1994-1995	WPIC Services Research Committee
90CA14599/05	CPS Operations and Service Delivery in Child Physical Abuse: A Process and Outcome Evaluation Principal Investigator	1994-1997	NCCAN (DHHS)
	Service Access, Needs, and Quality in the Treatment of Juvenile Sexual Abusers: A Systemic Evaluation Co-Principal Investigator (Elissa J. Brown, Ph.D., PI)	1997-1998	WPIC Services Research Committee
	Intentional vs. Unintentional Injury to Children: Development of Post-Trauma Attributions and Psychiatric Symptoms, Center for Injury Research and Control, pilot study. The Children's Hospital. Co-Principal Investigator (Elissa J. Brown, Ph.D., PI)	1997-1998	U.S. - CDC
P30 MH55123	CADPRC for Early-Onset Affective and Anxiety Disorders (David Brent, M.D., PI) Co-Investigator; Associate Director/ Services Core	1997-2002	NIMH
R10 MH56612	Familial Pathways to Early-Onset Suicide Attempts (David Brent, M.D., PI), Co-Investigator	1997-2002	NIMH
95/96-JC-01-7049	Community-based, Wraparound Mental Health Services for Juvenile Sex Offenders	1998-1999	PA Commission on Crime & Deliquency
MH57727	Effectiveness of Community Services for Conduct Problems. Principal Investigator	1998-2003	NIMH
	Comprehensive Mental Health Assessment and Treatment Of Juvenile Sexual Offenders: The "SSU/WPIC" Collaborative Treatment Program. Juvenile Accountability Incentive Block Grant. Principal Investigator.	1999-2001	PA Commission on Crime & Delinquency
	Mental Health Services Across Child Welfare Agencies (John Landsverk, Ph.D., PI). Co-Investigator.	1999-2004	NIMH

BIOGRAPHICAL INFORMATION FOR CRIS M. SULLIVAN, PH.D.

Cris Sullivan is Associate Professor of Ecological Psychology at Michigan State University, and Director of Research & Evaluation for the Michigan Coalition Against Domestic and Sexual Violence. Dr. Sullivan has been an advocate and researcher in the movement to end violence against women since 1982. She has received research grants from the National Institute of Mental Health, National Institute of Justice, and Centers for Disease Control and Prevention to examine the long-term effects of community-based interventions for battered women and their children. Dr. Sullivan has published extensively in the area of violence against women, with most recent articles including, "Reducing violence using community-based advocacy for women with abusive partners," (with D. Bybee, 1999. Journal of Consulting and Clinical Psychology, 67(1), 43-53); "How children's relationships to their mothers' abusers affects their adjustment," (with J. Juras, D. Bybee, H. Nguyen, & N. Allen, in press. Journal of Interpersonal Violence; and "Beyond searching for deficits: Evidence that physically and emotionally abused women are nurturing parents," (with H. Nguyen, N. Allen, D. Bybee, & J. Juras, in press. Journal of Emotional Abuse).

BIOGRAPHICAL SKETCH

Ross A. Thompson is Happold Distinguished Professor of Psychology at the University of Nebraska. He received his Ph.D. from the University of Michigan in 1981, and studies early sociopersonality development and the psycholegal applications of this research. He currently serves as Associate Editor of *Child Development* and edits a series of specialized volumes in developmental psychology for McGraw-Hill. His books include *Preventing Child Maltreatment through Social Support: A Critical Analysis* (Sage, 1995), *The Postdivorce Family: Children, Familes, and Parenting* (Sage, 1999), and *Early Brain Development, the Media, and Public Policy* (University of Nebraska Press, forthcoming).

Jeremy Travis
Director
National Institute of Justice

Jeremy Travis has served as Director of the National Institute of Justice since 1994 when he was nominated by President Clinton and confirmed by the United States Senate.

Before joining the National Institute of Justice, Mr. Travis was the Deputy Commissioner for Legal Matters of the New York City Police Department. While with the Department, he developed the Civil Enforcement Initiative, which won an Innovations in Government award from the Kennedy School of Government and the Ford Foundation; authored New York City's ban on assault weapons; drafted the Police Department's quality-of-life strategy, entitled "Reclaiming New York's Public Spaces"; and chaired the New York City Chancellor's Advisory Panel on School Safety.

In a previous position, Mr. Travis served as Chief Counsel to the Subcommittee on Criminal Justice of the House of Representatives Committee on the Judiciary under its Chairman, Rep. Charles E. Schumer. He served as Special Advisor to New York City Mayor Edward I. Koch, Assistant Director for Enforcement Services for the Mayor's Office of Operations and Special Counsel to the Police Commissioner. Prior to joining City government, Mr. Travis was the Marden and Marshall Fellow at the Center for Research on Crime and Justice at New York University's School of Law and served as Law Clerk to Judge Ruth Bader Ginsburg when she sat on the United States Court of Appeals.

Mr. Travis spent six years at the Vera Institute of Justice, an action research institute in New York City, where he managed demonstration programs on bail reform, judicial decision making and victim-witness assistance. He began his career in criminal justice working as a legal services assistant with the Legal Aid Society, New York City's indigent defense agency.

The recipient of a J.D. cum laude from the New York University School of Law, Mr. Travis was a member of the Law Review, named to the Order of the Coif, and awarded the Arthur Garfield Hays Fellowship in Civil Liberties. He also holds an M.P.A. from the New York University Wagner Graduate School of Public Service and a B.A. cum laude, with honors in American Studies, from Yale College.

Mr. Travis has taught courses on criminal justice, public policy, history and law at Yale College, New York University Wagner Graduate School of Public Service, and New York Law School. He has written and published extensively on constitutional law, criminal law, and criminal justice policy. He is a member of the Board of Trustees of the United Nations Interregional Crime and Justice Research Institute.

BEST COPY AVAILABLE

Pamela L. Whitney, MSW, LICSW

Pamela Whitney, Director of Domestic Violence and Family Support, began her work in the area of child abuse and neglect at The Children's Hospital, Boston, as the coordinator of the Child Protection Team, and as principal social worker in the Family Development Clinic.

Ms. Whitney has been with the Massachusetts Department of Social Services since 1986. She began with the Department as a health care consultant, and served as the liaison between DSS and the Massachusetts Committee for Children and Youth, an advocacy organization working to improve the delivery of health care services to children in foster and group care. She then joined the Office of Special Projects, where she started working with battered women's programs. Ms. Whitney co-founded the DSS Domestic Violence Unit, the first of its kind in the country. Ms. Whitney also directs Community Connections, the state's neighborhood based family support initiative, and other community partnership efforts.

Ms. Whitney received a Masters of Social Work degree from Boston University in 1981.

Carol W. Williams, D.S.W.

Carol W. Williams, D.S.W. joined the University of Pennsylvania School of Social Work faculty in July as a visiting professor of social work. Prior to her arrival at Penn, Dr. Williams had been the Associate Commissioner of the Children's Bureau at the Department of Health and Human Services' Administration for Children and Families (ACF) since March 1994. As Associate Commissioner, Dr. Williams was responsible for the management and oversight of ACF programs which focus on child protection and child welfare services that strengthen and support children and families; and which effectively enhance state and local child welfare programs and services. She served in this capacity since March of 1994. In 1996 Dr. Williams received additional responsibilities with the integration of the National Center for Child Abuse and Neglect (NCCAN) into the Children's Bureau. NCCAN activities included assisting States to meet their responsibilities for prevention of and intervention in cases of child abuse and neglect. With her extensive background and expertise in the area of child welfare, Dr. Williams will play a key role in the work of the School's new Center for Children's Policy, Practice, and Research.

During her tenure with the Children's Bureau, Dr. Williams administered and/or managed: the implementation of the Family Preservation and Family Support Programs; the revision of the IV-E Eligibility and Family Service Review process; the implementation of the Adoption and Foster Care Analysis and Reporting Systems (AFCARS); and the submission of the Department's response to the Presidential Executive Memorandum on Adoption — "Adoption 2002." Dr. Williams' contribution to policy and practice in the capacity of Associate Commissioner has been recognized by many, among them are the University of Southern California's award of "Lifetime Contributor to the Development of Policies and Programs for Underserved Populations," the National Association of Black Social Workers' "Outstanding Contributions Award," and the National Association of Public Child Welfare Administrators' "Award for Leadership in Public Child Welfare."

Prior to joining ACF, Dr. Williams was a senior associate at the Center for the Study of Social Policy, Washington, DC, where her work focused on the reform of state child welfare systems through foundation and litigation efforts. She served as the director of the National Child Welfare Leadership Center, University of North Carolina at Chapel Hill, which provided management and executive development seminars to child welfare leaders from across the nation. Dr. Williams held professorships at the University of North Carolina at Chapel Hill and the University of California, Los Angeles. She served as Distinguished Visiting Professor at New Mexico State University and North Carolina State University. In addition to her extensive involvement in child welfare issues, Dr. Williams has published a variety of articles in the areas of cultural competency, permanency planning and relative care.

Dr. Williams' began her career working for the Los Angeles County Departments of Adoptions and Probation. A native of Los Angeles, Dr. Williams received her undergraduate degree from the University of California at Riverside and her graduate and postgraduate degrees from the University of Southern California.

BEST COPY AVAILABLE

Dr. Oliver J. Williams, Executive Director of the Institute on Domestic Violence in the African American Community, is an Associate Professor in the Graduate School of Social Work at the University of Minnesota in Minneapolis. He is a practitioner as well as an academician. As a practitioner, he has worked in the field of domestic violence for more than 20 years and has provided individual, couples, and family counseling. He has been a child welfare and delinquency worker, worked in battered women's shelters, and developed and conducted counseling on partner abuse treatment programs. As an academician, Dr. Williams' research and publications have centered on creating effective service delivery strategies that will reduce the violent behavior among African Americans. Additionally, Dr. Williams writes about ethnically sensitive practice, as well as aging and elder maltreatment. He has conducted training nationally on research and service delivery issues in the areas of child abuse, partner abuse, and elder maltreatment. Dr. Williams also serves on several national advisory boards focused on the issue of domestic violence.

David A. Wolfe (Ph. D., University of South Florida) is Professor of Psychology and Psychiatry at the University of Western Ontario in London, Canada. He is a founding member of the Center for Research on Violence Against Women and Children at the University, and past President of Division 37 (Child, Youth, and Family Services) of the American Psychological Association. David has broad research and clinical interests in abnormal child psychology, with a special focus on child abuse, domestic violence, and developmental psychopathology. He has authored numerous articles on these topics, especially in relation to the impact of early childhood trauma on later development in childhood, adolescence, and early adulthood. Recent books include *Children of Battered Women* (with P. Jaffe and S. Wilson; Sage, 1990), *Preventing Physical and Emotional Abuse of Children* (Guilford, 1991), *Alternatives to Violence: Empowering Youth to Develop Healthy Relationships* (with C. Wekerle & K. Scott; Sage, 1996), *Abnormal Child Psychology* (with E. Mash; Wadsworth, 1999), and *Child Abuse: Implications for Child Development and Psychopathology, 2nd Edition* (Sage, 1999).

Michele D. Kipke, Ph.D.

Dr. Kipke is the Director of the Board on Children, Youth, and Families, and the Director of the Forum on Adolescence at the Institute of Medicine and the National Research Council of the National Academy of Sciences. She is also an Assistant Professor of Pediatrics within the Department of Pediatrics at the University of Southern California School of Medicine, an investigator for several National Institutes of Health and Centers for Disease Control and Prevention-funded research projects including: (a) national cooperative agreement study for the development of community-level HIV prevention programs for young Latino men who have sex with men, (b) a cross-sectional and longitudinal research study examining drug abuse as it relates to chronic homelessness among youth, (c) a study focusing on the risk unique to young women (which includes social network analysis and social mapping), (d) qualitative and quantitative research examining the nature of peer groups and other social networks among street youth and the impact of these networks on high risk behavior, decision-making and social support, and (e) qualitative research designed to examine the risk and protective factors associated with weapons possession and use among youth. She was the Associate Director of Research and Evaluation at Childrens Hospital Los Angeles, and the founding coordinator of the Substance Abuse Program within the Division of Adolescent Medicine at Childrens Hospital Los Angeles. She was awarded her degree in experimental/health psychology from the Albert Einstein College of Medicine specializing in behavioral medicine and interventions for children and adolescents. Since the early 1980s, Dr. Kipke has worked in the field of adolescent health, including treatment of substance abuse disorders, HIV risk and prevention, homelessness, and intentional and unintentional injuries. She remains actively involved in performing outcome and cost analyses of primary health care, community needs assessment, HIV-related medical and psychosocial services, and substance abuse and mental health treatment services for youth. She has written extensively on the subject of adolescents, health, substance abuse problems and HIV risk among high risk youth, and she serves as a consultant to the Centers for Disease Control and Prevention, the National Institutes of Health, the Center for Substance Abuse Treatment, the Department of Health and Human Services, and the World Health Organization. She is a member of the Technical Advisory Board of The Mentor Foundation.

Felicia G. Cohn, Ph.D.

Felicia Cohn joined the Board on Children, Youth, and Families as a Program Officer in November 1999, to serve as the Study Director for the Committee on the Training Needs of Health Professionals to Respond to Family Violence. Previously, she was with The George Washington University Medical Center, where she served as Director of the Program in Bioethics in the Department of Health Care Sciences and as a Senior Scientist with the Center to Improve Care of the Dying. There, Dr. Cohn taught in the medical and health-related professional programs, created and revised medical school curricula, developed hospital ethics policy, and developed and implemented several research initiatives on end-of-life care programs, prison health care, and quality improvement. She serves as an appointed member-at-large of the District of Columbia Health Policy Council, on the George Washington University Hospital Ethics Committee, and on a National Institutes of Health Data and Safety Monitoring Board and continues to teach in the Health Care Sciences program at George Washington. She has written extensively on end-of-life care issues and ethics education, and consults regularly on a number of ethical issues. Dr. Cohn received her Ph.D. in Religious Ethics (Bioethics) from the University of Virginia.

Child Witness to Violence Project

Boston Medical Center
One Boston Medical Center Place, MAT 5
Boston, MA 02118
Telephone: (617) 414-4244
Fax: (617) 414-7915

PROJECT DESCRIPTION

The Child Witness to Violence Project (CWVP) is a counseling, advocacy, and outreach project that targets young children who witness violence. This project was established in 1992 to serve the needs of hidden victims of violence: children who are bystanders to community and domestic violence. CWVP is staffed by a multi-cultural, multi-lingual staff of social workers, psychologists, early childhood specialists and a consulting child psychiatrist. It is run under the auspices of the Department of Developmental and Behavioral Pediatrics at Boston Medical Center. Goals of the project include:

- To identify young children who witness acts of significant violence.
- To help young children heal from the trauma of witnessing violence by providing developmentally appropriate counseling for them and for their families.
- To provide consultation and training to the network of caregivers in the lives of young children in order that they may more effectively help children who are exposed to violence.

The Child Witness to Violence Project received 225 referrals for service in 1998. 10% of these referrals were for children under the age of three; 48% referred were between the ages of 3 and 6; 87% of referrals are under age 7.

NEED FOR PROJECT

In a study conducted in the outpatient pediatric clinic at Boston City Hospital, 115 mothers were interviewed about the violence their children were exposed to. ***One in ten children had witnessed a knifing or shooting by the age of six.*** Half of these children witnessed violence in the home; half in the community. Even though they may not be directly involved, children who witness violence are also victims and need appropriate support services.

PREMISES OF THE CHILD WITNESS TO VIOLENCE PROJECT

- There is emphasis on rapid response and intervention as soon as possible after the trauma occurs.
- The assessment and treatment process includes working with the child in the context of his/her environment. This includes intervention with the family and other systems that may impact on a child's ability to cope with violence, particularly day care, schools, the health care system, and the legal system.

COUNSELING AND ADVOCACY SERVICES

- Intervention to stabilize the environment of the child.
- Intervention with families to facilitate their ability to support the children.
- Play therapy with the child.
- Consultation to schools and day care centers to facilitate the child's adjustment.

REFERRALS

Referrals to CWVP have come from a wide variety of sources, including the police, health care providers, Head Start and other early childhood programs, schools, attorneys, shelters for battered women, and court -sponsored victim services programs. Referral criteria include:

BEST COPY AVAILABLE

- The child must be 8 or younger.
- The child must have witnessed an act of significant violence.
- Children who are victims of violence will be referred to the appropriate service within the hospital.

TRAINING/CONSULTATION

- Consultation and supervision provided to domestic violence shelters on establishing child services within shelters.
- Annual summer training institute: "Working with young children who are affected by violence"
- Collaboration with Family Communications, Inc. (producers of Mister Roger's Neighborhood) on the production of training videos for teachers working with children who are affected by violence.
- Consultation to early childhood programs on the role of day care in stabilizing children exposed to violence.
- Development of a curriculum to train mental health clinicians in clinical treatment of young children who have witnessed domestic violence. This curriculum will be disseminated in the fall of 1999.

RELATED PROJECTS

- A partnership with the Boston Police Department to provide training on issues related to children and violence. This collaboration with law enforcement has provided a national model of intervention that has been recognized both locally (Runner-up, Mayor's Awards for Excellence) and nationally (Finalist, Ford Foundations Innovations Award).
- Collaboration with the Massachusetts Attorney General's Office to launch a statewide training initiative to help communities identify and support children who have witnessed domestic violence.
- The Partnership Project: A collaboration with Simmons College School of Social Work and Mass. Dept. of Social Services to provide training and consultation to DSS staff on domestic violence issues.
- A community based initiative to work in six neighborhood health centers to provide services to children who witness domestic violence.
- Project BounceBack: A collaboration with the Better Homes Fund to identify and serve homeless families and their children age 0-6 who have been exposed to violence.

FUNDING

The Child Witness to Violence Project receives funding from the following sources:

- The Bureau of Justice Assistance through the Mass. Attorney General's Office
- The Mass. Off ice of Victim Assistance through the Office for Victims of Crime, U.S. Dept. of Justice
- Boston Medical Center
- Private Foundations
- Individual contributions

For more information , contact:

The Child Witness to Violence Project
Boston Medical Center, MAT 5
Boston, Ma. 02118
(617) 414-4244

Cwvppr4

The Child Development-Community Policing Program's Domestic Violence Intervention *Project is an extension of the CD-CP 24 hour consultation service, which brings together* police, mental health professionals and domestic violence advocates from several community agencies to develop and implement coordinated interventions for battered women and their children.

The project includes the following components:

A. CD-CP acute response

Police officers throughout the city may contact the CD-CP 24 hour on-call service for consultation and immediate response by clinicians in any case in which children witness or become involved in incidents of domestic violence. Immediate contact with an advocate/clinician team is offered to mothers by the responding patrol officer or by the Domestic Violence Unit detective who reviews the case. When accepted by the battered woman, an interdisciplinary consultation service team meets with the woman and children to begin a process of safety planning, crisis intervention, clinical assessment and acute treatment. Detectives and/or patrol officers make follow-up visits to the home of the victim and/or the perpetrator to assure physical safety and compliance with protective orders and to complete case investigations. Clinicians and advocates make follow-up visits and/or telephone contacts to determine the impact of the violence on both mothers and their children and to respond as needed. Officers, clinicians, domestic violence advocates and court personnel collaborate in assessing the level of physical danger to the mother and children and in assisting the mother to plan for her own and her children's safety.

B. Weekly domestic violence team meeting

An interdisciplinary team meeting attended by police, clinicians and advocates has met weekly since January, 1998 to review cases and coordinate strategies. The team provides a forum for representatives of different institutions to share information, request assistance in difficult cases, brainstorm collaborative responses that may increase victims' security, and follow the progress of cases over time. Regular members of this team include representatives of neighborhood police patrol in the target policing district of Fair Haven, detectives from the centralized police Domestic Violence Unit, CD-CP clinicians, court-based advocates from Domestic Violence Services of Greater New Haven (a nonprofit agency which maintains a shelter for battered women and provides a range of other services in the community, e.g., support groups, community education and court-based advocacy) and community-based domestic violence advocates from the Coordinating Council for Children in Crisis (a nonprofit agency which provides a variety of advocacy and supportive services to children and families, e.g., advocacy and counseling for victims of domestic violence and other crimes, parent aids, parent education classes, support groups).

C. Collaborative follow-up interventions developed on case-specific basis

The project's approach includes standardized data collection regarding details of the most recent violent event, history of previous violence, children's involvement, acute psychological

responses of both woman and children and interventions applied. A flexible intervention protocol addresses each case individually from the perspectives of safety, law enforcement, physical needs and psychological status in order to develop responses that are tailored to the needs and wishes of the particular woman and her children. The following is an outline of the coordinated intervention approach.

1. A patrol officer or detective informs the victim of the availability of advocacy, supportive and other services for herself and children, including assistance with safety planning, accessing basic needs and psychological support following trauma. An informational pamphlet is made available at the time of police contact (see attached), although contact with Child Study Center and other advocacy personnel is voluntary. Follow-up by police and other law enforcement personnel is not dependent on the victim's acceptance of contact with clinicians and/or advocates (see below).

2. Immediate CD-CP response is available on a 24 hour basis as described in paragraph A above. In those situations in which the referral from police is received after the acute event or the battered woman requests that contact not occur until a later time, a clinician and/or advocate contacts the woman to arrange a meeting. First meetings may be at home, a police station, a clinic or other location depending on issues of safety, transportation and the victim's comfort. First meetings usually include children, but may take place with the mother alone if she wishes. A police officer may be present or not, depending on whether the officer has established a relationship with the victim that supports her feelings of safety and security. Officers consult with clinicians and advocates regarding safety of home visits if an officer is not present.

3. The intervention begins with a careful consideration of issues of immediate safety, followed by identification of urgent needs for concrete assistance (e.g., housing, food, day care) and any acute psychological symptoms of mother and children (e.g., sleep disturbance, intrusive thoughts, hyper-arousal). The advocate/clinician team and/or officer provides information regarding the criminal justice process, court orders, shelters, social service system, as well as information regarding common psychological responses to trauma for adults and children and guidance to parents for assisting children to cope with the effect of witnessing domestic violence. The CD-CP team provides linkage to other professionals who may be of specific assistance (e.g., court-based victim advocates, shelter hot-line workers, legal aid attorneys, adult probation officers). In addition, the capacity to provide clinical assessment of a woman's post-traumatic response is a useful tool in informing other interventions essential to safety planning -- e.g., how should police and courts best approach a terrorized woman in order to maximize her participation in legal decision-making and her experience of self determination.

4. Follow-up police contact may be made by the neighborhood patrol officer or Domestic Violence Unit detective. Follow-up by specialized detectives is most likely to involve ongoing investigative issues, enhancement of charges, coordination with prosecutors, etc. Patrol follow-up in the target district of Fair Haven has been assigned to a team of four officers (two on day shift and two on evening shift). Assigned officers assume personal responsibility for planning and implementing a plan to increase victim and witness safety in the designated cases and work closely with advocates and clinicians who are involved with a woman and children.

Individual officers who are assigned personal responsibility for cases provide battered women and their children with a consistent person in their neighborhoods with whom they may form a real relationship in the service of increasing their security. Personal case assignment is also intended to increase officers' personal investment and their ability to develop specialized expertise and knowledge in this phase of the work.

5. The advocacy/clinical follow-up includes a wide range of supportive, therapeutic and case management services depending on the particular woman and children's needs. The following are some examples of follow-up activities provided by project staff:
(a) assistance in obtaining court orders of protection; (b) advocacy with prosecutors for increased bond, specific conditions of release, addition of charges, etc.; (c) close coordination of information flow among police patrol, prosecutor, probation, advocates and victim; (d) regular supportive contact with a battered woman and her children to assist in developing a greater sense of security and autonomy; (e) advocacy with other institutions to secure a variety of social services; (f) provision of information regarding adults' and children's common responses to violence and trauma; (g) clinical assessments of children and/or mother; and (h) ongoing psychotherapy for children and/or mother if needed.

D. Regular police ride alongs by community-based CD-CP clinician

Beginning in September, 1998, Dr. Robert Casey, a CD-CP psychologist has been spending four to six hours per week on site in the Fair Haven police district meeting with patrol officers and supervisors in the neighborhood substation and riding with officers as they respond to calls for service, primarily during the evening hours, when most domestic violence incidents occur. Dr. Casey's regular weekly ride alongs have built closer working relationships between him and the cadre of officers assigned to the evening shift in Fair Haven, and have provided an additional resource for officers in the district to obtain consultation and assistance on difficult domestic violence cases, particularly those involving children. Officers were extremely receptive to Dr. Casey's availability because they had come to recognize the complexity of domestic violence cases. They regularly speak with him about their frustration at repeat calls for service, their awareness of the need for more advocacy and support services for battered women and their concern about the impact of domestic violence on children. Dr. Casey provides approximately three case consultations each evening that he is present in the district.

E. Case tracking and follow-up

All cases referred to the project are tracked via the CD-CP computer-based data collection system CAPERS, which records identifying information, nature of the incident precipitating the referral, nature of the immediate CD-CP response, and number and nature of follow-up contacts. Domestic violence cases are also tracked through the police department to determine the existence of and compliance with court orders of protection, repeat calls for service, and level of violence. Women and children receiving clinical services are also tracked to determine the nature and course of their psychological responses to the violent incident(s), e.g., levels of anxiety. Case review allows for modifications in the plan of intervention in each case, and allows the project to learn more about which types of coordinated interventions

are likely to be most successful in different types of cases.

The Youth Relationships Program

The Youth Relationships Project (YRP) began in 1991 as an educational, preventative program designed to help youth (grades 8-11) develop healthy, non-abusive relationships with dating partners and peers. The YRP targets the prevention of violence in dating relationships as a way of interrupting the cycle of child abuse and woman abuse in future relationships. Accordingly, it was designed to provide awareness and interpersonal skills development through education, problem-solving, and social action opportunities for adolescents. Some of the participants in the program have been at-risk of becoming victims or perpetrators of violence due to their family backgrounds, whereas others have participated through their schools. The underlying goal is to provide them with the requisite skills before problems emerge, rather than treating problems after they have become entrenched in their personal relationships. Thus, the YRP is a proactive, educational and experiential program, not a treatment program for identified youth.

Four primary goals form the foundations for the program, which are typically achieved in 30 hours of participatory group pr classroom meetings: 1) to help youth develop an understanding of the foundations of abusive behavior, including and examination of their own attitudes and beliefs about relationship violence; 2) to develop and enhance skills needed to build healthy relationships, and to recognize and respond to abuse in their own relationships and in relationships of their peers; 3) to understand the societal influences and pressures that can lead to violence and to develop skills to respond to these influences; and 4) to increase their social competencies through community involvement and social action.

The YRP is currently operated as a community-based program, but the curriculum is flexibly designed to allow the exercises and ideas to be taught through the school system. Youth participate in small-group discussions that build on their current strengths and teach them how to choose appropriate alternatives to abuse and violence. The program helps youth to understand the critical issues related to healthy versus abusive relationships, to develop skills to build healthy relationships, and to use new attitudes and skills through community involvement and social action.

We are planning to expand the YRP to other cities and populations. Our plans include Spanish translation and more input from various cultural communities. We also plan to continue our research evaluation of the program in different communities in the US and Canada.

Institute on Domestic Violence in the African American Community

Mission

The purpose and intent of the Institute on Domestic Violence in the African American Community is illustrated by its mission:

To provide an interdisciplinary vehicle and forum by which scholars, practitioners, and observers of family violence in the African American community will have the continual opportunity to articulate their perspective on family violence through research findings, the examination of service delivery and intervention mechanisms, and the identification of appropriate and effective responses to prevent/reduce family violence in the African American community.

Goals and Objectives

Create a community of African American scholars and practitioners working in the area of violence in the African American community;

Further scholarship in the area of African American violence;

Raise community consciousness of the impact of violence in the African American community;

Inform public policy;

Gather and disseminate information;

Organize and facilitate local and national conferences and training forums;

Secure resources to support and sustain the organization; and

Identify community needs and recommend best practices.

Background

At the first National Conference on Domestic Violence sponsored by the Office of Community Services in 1993, a group of five scholars and practitioners informally gathered to discuss their concerns about the plight of the African American community in the area of domestic violence. One clear perspective from that group was that the work being done in the field(s) of domestic violence was designed from a "one-size-fits-all" perspective. Conventional wisdom is that domestic violence means the same thing to all people, therefore, policies and intervention strategies have typically been designed from a

singular mainstream perspective. Many in the field also note the lack of information concerning strategies to address this problem among African Americans. There is also a lack of scholars and practitioners in the field who are able to provide guidance in this area. The group believed that such mainstream perspectives and beliefs explain why approaches and responses, which have been successful with whites, have failed to address the needs of African Americans. To be more responsive to the community, academics and practitioners in the field accurate information, guidance and support. It became clear to this group that the crisis of violence in the African American community would change only if some individuals or groups focused attention on the problem and took action.

Since the 1993 meeting, this group has expanded its membership and become the steering committee for the Institute on Domestic Violence in the African American Community. The group has focused on setting an agenda respond to the needs of this community. Sponsored by the Office of Community Services, Administration for Children and Families, U.S. Department of Health and Human Services, the Institute on Domestic Violence in the African American Community is focused on setting an agenda to reduce/eliminate domestic violence in the African American community. To this end, the group examines the interconnectedness between various types of violence.

The Overlap Between Child Maltreatment and Woman Abuse

A great deal of attention is now being paid to both violence against women and to the effects of such violence on their children. One question that commonly arises is: How often does child maltreatment and woman battering occur in the same families? This document briefly summarizes what is known about the overlap between these two forms of abuse in the same families.

We currently have a very limited picture of this overlap. Existing studies allow us to state what degree of overlap exists, but - as will be seen below - not much more than this. Part of the problem is that most studies published to date report simple statistics on the percentage of overlapping violence in families based on survey questions or case-record reviews that were carried out for other purposes. The data on the overlap is often mentioned as an aside to the primary findings of a particular study. Hughes' (1988) study of children is a good example of this. Hughes mentions that 60% of the children accompanying battered women to a shelter were reported by their mothers to have also been physically abused. The focus of Hughes' study was the psychological and behavioral problems associated with a child's witnessing violence in the home, not on the overlap between child maltreatment and woman battering. As a result, we have an estimate of the overlap in this shelter-based population but little more about how these forms of abuse are interconnected.

How Families Were Identified

It is helpful to review the methods used to collect research data about families when trying to understand the findings of studies available on overlapping abuse. Researchers have come to study the overlap between child maltreatment and woman abuse mostly from two different directions. One strategy has been to identify evidence of woman battering in families where known cases of child maltreatment exist. These studies have most often examined existing records in cases of child abuse and looked for information indicating that a child's mother was also being abused. For example, Hangen (1994) looked at the Massachusetts Department of Social Services' Child Protection case records for indications that an incident of adult domestic violence had occurred since the last case review. He examined computerized records for all active child protection cases in Massachusetts over a seven month period and found that the average incidence of adult victimization recorded in cases was 32.48% across all state child protection offices. The statewide average overlap jumped to 48.2% when Hangen added cases where records indicated a service goal of protecting the child from adult domestic violence. In another study, Stark and Flitcraft (1988) used suspected cases of child abuse and neglect at a major hospital to then search for indications of victimization in the mother's medical records. They found that records of 45%

of these children's mothers showed some evidence of being battered.

A second strategy has been to look for evidence of child abuse in the families where abuse of the mothers is known to exist. The percentages of overlap offered include only battered women with children present in the home, not all battered women. Some of these studies have drawn their data from interviews of women residing in battered women's shelters, others have advertised in the media to recruit families, and still others have located battered women who were using other social services. For example, Bowker, Arbitell and McFerron (1988) advertised in a national magazine, developed a national sample of 1,000 battered women -775 of which had children present in the home -and found that 70% of the wife beaters were also reported to abuse their children.

Accuracy of Reports

It is likely that the results one finds in a particular study are strongly influenced by the source of the data collected. We know from other studies that men and women differ in their level of reporting violence (see Edleson & Brygger, 1986; Szinovacz, 1983) and that children report different effects of witnessing violence than do their mothers or fathers (see Sternberg, Lamb & Dawud-Noursi, 1998). In the same way, child protection records are likely to give a very different picture of overlapping abuse than reports by battered women in a shelter or using another social service. Few studies have used multiple sources that include data collected from both battered women and from child protection sources. One such study (Petchers, 1995) found that 46% of the battered women interviewed reported that at least one of their children had been maltreated; because some women reported that one, but not all of her children, had been abused, this totaled 34% of the children in the study. Interestingly, when Petchers examined county child protection records she found that 62% of the children in her study had reports of child maltreatment. Petchers found that mothers' reports and those of the county were consistent in only 41% of the cases. Mothers reported many incidents of child maltreatment that were not recorded in county files and vice versa.

Still other studies examine the overlap between forms of abuse in one's family of origin as recalled by adults many years later. For example, Rosenbaum and O'Leary (1981) asked adult subjects in their study to recount their childhood experiences. The women in this study reported that 82% of their husbands who witnessed one parent abuse another (no gender specified) were also physically abused as children.

Studies that rely on only one source of information are likely to underestimate the overlap. One needs to consider carefully the source of information reported and likely reasons for under or over-reporting of violent incidents. In some studies mothers may be fearful of reporting child maltreatment unknown to official sources. In other studies county child protection agencies are unlikely to record all instances of child maltreatment, or adult recollections of childhood experiences may be highly edited.

Reported Levels of Overlapping Violence

The Table below lists a selection of the available studies by author name(s) and date of publication, the sources of the information from which estimates were obtained, and the percent of overlap reported. Given the varied methods used and limitations pointed out above, one can still state that the majority of studies indicate that from 30% to 60% of families where either child maltreatment or woman battering is identified it is likely that both forms of abuse exist. For a more complete listing, see recent articles by Appel and Holden (1998) and Edleson (1999).

The Dynamics of Overlapping Violence

The above overview clearly indicates that there is a significant overlap between child abuse and woman battering in the same families. Most of the current research on this topic does not, how-

Table: Studies on the Overlap Between Child Maltreatment and Woman Battering

Studies of Families with Known or Suspected Child Maltreatment

Authors & date	Sample	Information source	Percent of assaulted spouses in child maltreatment cases
Hangen (1984)	All child protection cases in Massachusetts over a 7 month period	Mass D.S.S. child protection service reviews	32% of the records recorded adult domestic violence since last service review; 42% if a stated goal of protecting adult was included
Stark & Flitcraft (1988)	116 mothers of children in a hospital setting referred for maltreatment	Medical records in suspected cases of child maltreatment	45% of mothers' medical records showed evidence of battering history
Stanley & Goddard (1993)	20 child abusive families in Victoria, Australia	Four case files randomly selected from case loads of each of five CPS workers	60% of case files showed evidence of violence between two adult care-givers

Studies of Families with Known Spouse Assault

Authors & date	Sample	Information source	Percent of maltreated children in cases of spouse assault
Dobash (1976-77)	933 cases of assault on wives in Great Britain	British police and court documents	6.5% of the cases showed evidence of violence also directed at the child
Hilberman & Munson (1977-78)	40 African American and 20 white battered women receiving mental health services	Interviews with battered women, clinic charts and observation	Child physical or sexual abuse identified in 20 families. Either "husband beats wife who beats children and/or husband beats both his wife and children" (p. 463)
Suh & Abel (1990)	258 women victims of spousal assault who had sought refuge in a battered women's shelter	Shelter's intake and social history questionnaire	40% of the women reported that their spouse physically abused their children
Petchers (1995)	51 mothers who were admitted to a shelter and their 116-126 children	Battered mothers' reports; child protection records	46% of children abused as reported by mothers; 62% of children abused as reported in county records
Straus & Gelles (1990)	National random survey of 6,002 American adults	Telephone interviews of adults	50% of fathers who frequently beat their wives also frequently abused their children
Walker (1984)	403 battered women in the Rocky Mountain region	Face-to-face interviews lasting 4-5 hours plus 1-2 hours of paper/pencil measures	53% of the women reported that their abuser also abused their children. 28% of the women also disclosed that they abused the children
Hughes (1988)	Mothers of 97 children, all residing in a shelter for battered women	Battered women's reports with verification from shelter staff	60% of the women reported their children were physically abused
Bowker et al. (1988)	National sample of 775 battered women with children	Battered women's reports on written questionnaires	70% of families with children present the wife beater also beat the children
Rosenbaum & O'Leary (1981)	52 self-referred battered women receiving services and 40 women in comparison groups	Women's reports of husband's childhood experiences	82% if husbands who witnessed parental violence had also been abused as a child

VAWnet is a project of the National Resource Center on Domestic Violence
800-537-2238 TTY 800-553-2508 Fax 717-545-9456

BEST COPY AVAILABLE

ever, indicate how these forms of violence co-occur, whether one precedes the other, or what impact their combination has on adult and child victims.

Bowker et al.'s (1988) study does shed some light on these dynamics. In addition to a high degree of overlap, Bowker and his colleagues found that the severity of abuse to a woman is associated with the severity of abuse to children in the home. That is, the more severely a woman is battered the more severely her child is likely to be abused. They found that child abuse was less severe than woman battering in the families studied. They also found that the more dominant a husband is in a family's decision making, the more likely a child is to be abused. Finally, the larger the number of children in a family the more likely there is to be child abuse in the home.

Bowker et al. studied only children who were biologically related to the abuser. Others have reported that the presence of children fathered by previous male partners put women at greater risk of being abused (Daly, Singh & Wilson, 1993) and that the presence of a step-parent put children at greater risk of being abused (Wilson & Daly, 1987). Rosenbaum and O'Leary (1981) reported that men who batter their wives were much more likely than others to have grown up in homes where adult domestic violence was occurring. Similarly, Suh and Abel (1990) found that batterers who were abused as a child were more likely to abuse their own children.

Many questions regarding the dynamics of this overlap remain unanswered at this point. These include, for example, the relationship between a mother being beaten and her own use of violence toward her children. Almost 20 years ago, Hilberman and Munson (1977-78) suggested that one possible scenario in families was "husband beats wife who beats children"; (p. 463). More recently, Straus and Gelles (1990) reported that women who were beaten were at least twice to abuse their children when compared to non-abused women. Walker (1984) reported that while 53% of the batterers were reported to abuse their children, 28% of the women she interviewed also reported perpetrating abuse against their children. These studies suggest some type of link between woman battering and subsequent abuse of the child by the mother. An in-depth understanding of this link, however, remains very unclear and in need of study.

Similarly, there are very few studies among those reviewed here that identify, much less discuss, the different dynamics of this overlap within varied racial, ethnic and cultural subgroups. Only a few studies state the racial, ethnic or cultural composition of their samples. Even fewer examine differences in regard to racial, ethnic or cultural influences on the overlap between these forms of domestic violence.

Conclusion

This brief review clearly suggests that there is a large overlap between child maltreatment and woman battering. Our present understanding of the link between woman and child abuse is limited to rough estimates based mostly on the analysis of records not originally intended for this purpose. Many questions remain to be answered and our understanding would be greatly enhanced by in-depth studies of the families in which woman abuse and child abuse jointly occur.

Author of this document:
Jeffrey L. Edleson, Ph.D.
University of Minnesota
School of Social Work
February 1997 (revised April 1999)

For more information see:

There are several recent papers that should provide you with greater information on this topic. Many of these are available electronically and include:

In the Best Interest of Women and Children: A Call for Collaboration Between Child Welfare and Domestic Violence Constituencies is a briefing paper by Susan Schechter and Jeffrey L. Edleson prepared for a Wingspread Conference of a similar title. It was reprinted in the Spring 1995 issue of *Prevention Report* from the National Resource Center for Family Centered Practice at the University of Iowa. It was also reprinted in the Fall 1995 issue of *Protecting Children* (Volume 11, No. 3) from the American Humane Association. (http://www.mincava.umn.edu/papers/wingsp.htm)

Mothers & Children: Understanding the Links Between Woman Battering and Child Abuse is a briefing paper by Jeffrey L. Edleson presented at the Strategic Planning Workshop on Violence Against Women, National Institute of Justice, Washington, DC, March 31, 1995. (http://www.mincava.umn.edu/papers/nij.htm)

Evaluation of a protocol to identify battered women during investigations of child abuse and neglect by Randy H. Magen, Kathryn Conroy, Peg McCart Hess, Ann Panciera, and Barbara Levy Simon at Columbia University School of Social Work. This paper was presented at the 4th International Family Violence Research Conference, University of New Hampshire, Durham, New Hampshire, July 22, 1995. (http://www.columbia.edu/~rhm5/FV_PAPER.html)

Also available are several recent bibliographies on this topic:

Children Who Witness Violence: Research & Intervention by Jeffrey L. Edleson. (http://www.mincava.umn.edu/bibs/bibkids.htm)

The Link Between Child Maltreatment and Woman Battering by Melody Bialke & Anna Hagemeister. (http://www.mincava.umn.edu/bibs/bibchwom.htm)

Woman Abuse Co-Existing with Child Maltreatment by Randy H. Magen. (http://www.columbia.edu/~rhm5/wacanbib.html)

The Minnesota Center Against Violence and Abuse operates a World Wide Web-based Electronic Clearinghouse at http://www.mincava.umn.edu that you may wish to search for more recent additions to the above list.

References

Appel, A. E., & Holden, G. W. (1998). The co-occurrence of spouse and physical child abuse: A review and appraisal. *Journal of Family Psychology, 12*(4), 578-599.

Bowker, L. H., Arbitell, M., & McFerron, J. R. (1988). On the relationship between wife beating and child abuse. In. K. Yllo, & M. Bogard (Eds.), *Feminist Perspectives on wife abuse* (pp. 158-174). Newbury Park, CA: Sage.

Daly, M., Singh, L. S., & Wilson, M. (1993). Children fathered by previous partners: A risk factor for violence against women. *Canadian Journal of Public Health, 84,* 209-210.

Dobash, R. E. (1976-1977). The relationship between violence directed at women and violence directed at children within the family setting. Appendix 38, *Parliamentary Select Committee on Violence in the Family*. London: HMSO.

Edleson, J. L. (1999). The overlap between child maltreatment and woman battering. *Violence Against Women, 5*(2), 134-154.

Edleson, J. L., & Brygger, M. P. (1986). Gender differences in reporting of battering incidents. *Family Relations, 35,* 377-382.

Hangen, E. (1994). *D.S.S. Interagency Domestic Violence Team Pilot Project: Program data evaluation*. Boston: Massachusetts Department of Social Services.

Hilberman, E., & Munson, K. (1977-78). Sixty battered women. *Victimology, 2,* 460-470.

Hughes, H. M. (1988). Psychological and behavioral correlates of family violence in child witnesses and victims. *American Journal of Orthopsychiatry, 58,* 77-90.

Petchers, M. (1995). *Child maltreatment among children in battered mothers' households*. Paper presented at the 4th International Family Violence Research Conference, Durham, NH.

Rosenbaum, A., & O'Leary, K. D. (1981). Children: The unintended victims of marital violence. *American Journal of Orthopsychiatry*, 51, 692-699.

Stanley, J., & Goddard, C. (1993). The association between child abuse and other family violence. *Australian Social Work, 46,* 3-8.

Stark, E., & Flitcraft, A.H. (1988). Women and children at risk: A feminist perspective on child abuse. *International Journal of Health Services, 18,* 97-118.

Sternberg, K. J., Lamb, M.E., & Dawud-Noursi, S. (1998). Using multiple informants to understand domestic violence and its effects. In G. W. Holden, R. A. Geffner, & E. N. Jouriles, (Eds.), *Children exposed to marital violence: Theory, research, and applied issues*. Washington, DC: American Psychological Association.

Straus, M. A., & Gelles, R. J. (1990). *Physical violence in American families*. New Brunswick, NJ: Transaction Publishers.

Suh, E., & Abel, E. M. (1990). The impact of spousal violence on the children of the abused. *Journal of Independent Social Work*, 4(4), 27-34.

Szinovacz, M. E. (1983). Using couple data as a methodological tool: The case of marital violence. *Journal of Marriage and the Family*, 45, 633-644.

Walker, L. E. (1984). *The battered woman syndrome*. New York: Springer.

Wilson, M., & Daly, M. (1987). Risk of maltreatment of children living with stepparents. In R. J. Gelles, & J.B. Lancaster, (Eds.), *Child abuse and neglect: Biosocial dimensions* (pp. 215-232). New York: Aldine de Gruyter.

Problems Associated with Children's Witnessing of Domestic Violence

Children who witness violence between adults in their homes have become more visible in the spotlight of public attention. The purpose of this document is to further an understanding of the current literature on the effects of witnessing adult domestic violence on the social and physical development of children. Out of 84 studies reporting on children's witnessing of domestic violence originally identified, 31 studies met criteria of rigorous research (see Edleson, 1999), with 18 of them comparing children who witnessed adult domestic violence to other groups of children, 12 others using multiple regression procedures to compare subjects along a continuum of violence exposure or by demographic characteristics, and one study applying qualitative research methods. The findings of these 31 studies can be divided into three major themes: (1) the childhood problems associated with witnessing domestic violence; (2) the moderating factors present in a child's life that appear to increase or decrease these problems; and (3) an evaluation of the research methods used in the studies reviewed.

Children's Problems Associated with Witnessing Violence

Reviewed studies report a series of childhood problems statistically associated with a child's witnessing domestic violence. These problems can be grouped into the three main categories presented in more detail below: (1) behavioral and emotional; (2) cognitive functioning and attitudes; and (3) longer-term.

Behavioral and emotional problems

The area in which there is probably the greatest amount of information on problems associated with witnessing violence is in the area of children's behavioral and emotional functioning. Generally, studies using the Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983) and similar measures have found child witnesses of domestic violence to exhibit more aggressive and antisocial (often called "externalized" behaviors) as well as fearful and inhibited behaviors ("internalized" behaviors), and to show lower social competence than other children. Children who witnessed violence were also found to show more anxiety, self-esteem, depression, anger, and temperament problems than children who did not witness violence at home. Children from homes where their mothers were being abused have shown less skill in understanding how others feel and examining situations from others' perspectives when compared to children from nonviolent households. Peer relationships, autonomy, self-control, and overall competence were also reported significantly lower among boys who had experienced serious physical violence and been exposed to the use of weapons between adults living in their homes.

Overall, these studies indicate a consistent finding that child witnesses of domestic violence exhibit a host of behavioral and emotional problems. A few studies have reported finding no differences on some of these measures but these same studies found significant differences on other measures.

Another aspect of the effects on children is their own use of violence. Social learning theory would suggest that children who witness violence may also learn to use it. Several researchers have attempted to look at this link between exposure to violence and subsequent use of it. Some support for this hypothesis has been found. For example, Singer et al. (1998) studied 2,245 children and teenagers and found that recent exposure to violence in the home was a significant factor in predicting a child's violent behavior.

Cognitive functioning and attitudes

A number of studies have measured the association between cognitive development problems and witnessing domestic violence. While academic abili-

ties were not found to differ between witnesses and other children (Mathias et al., 1995), another study found increased violence exposure associated with lower cognitive functioning (Rossman, 1998). One of the most direct consequences of witnessing violence may be the attitudes a child develops concerning the use of violence and conflict resolution. Jaffe, Wilson and Wolfe (1986) suggest that children's exposure to adult domestic violence may generate attitudes justifying their own use of violence. Spaccarelli, Coatsworth and Bowden's (1995) findings support this association by showing that adolescent boys incarcerated for violent crimes who had been exposed to family violence believed more than others that "acting aggressively enhances one's reputation or self-image" (p. 173). Believing that aggression would enhance their self-image significantly predicted violent offending. Boys and girls appear to differ in what they learn from these experiences. Carlson (1991) found that boys who witnessed domestic abuse were significantly more likely to approve of violence than were girls who had also witnessed it.

Longer-term problems

Most studies reviewed above have examined child problems associated with recent witnessing of domestic violence. A number of studies have mentioned much longer-term problems reported retrospectively by adults or indicated in archival records. For example, Silvern et al.'s (1995) study of 550 undergraduate students found that witnessing violence as a child was associated with adult reports of depression, trauma-related symptoms and low self-esteem among women and trauma-related symptoms alone among men. Witnessing violence appeared to be independent of the variance accounted for by the existence of parental alcohol abuse and divorce. In the same vein, Henning et al. (1996) found that among 123 adult women who had witnessed domestic violence as a child greater distress and lower social adjustment existed when compared to 494 non-witnesses. These findings persisted even after accounting for the effects of witnessing parental verbal conflict, being abused as a child, and level of reported parental caring.

Factors Influencing the Degree of Problems Associated with Witnessing Violence

Several factors appear to moderate the degree to which a child is affected by witnessing violence. As will be seen below, a number of these factors also seem to interact with each other creating unique outcomes for different children.

Abused and witnessing children

Hughes, Parkinson and Vargo (1989) have suggested that both witnessing abuse and also being abused is a "double whammy" for children. Their study compared children who were both abused and had witnessed violence to children who had only witnessed violence and to others who had been exposed to neither type of violence. They found that children who were both abused and witnesses exhibited the most problem behaviors, the witness-only group showed moderate problem symptoms and the comparison group the least. This same pattern appears in series of other studies. Children seem to agree. In one study they indicated that the experience of being abused or both abused and a witness is more negative than witnessing adult domestic violence alone (McClosky, Figueredo & Koss, 1995).

The combination of being abused and witnessing violence appears to be associated with more serious problems for children than witnessing violence alone. Silvern, et al. (1995) found, however, that after accounting for the effects of being abused, adult reports of their childhood witnessing of interparental violence still accounted for a significant degree of their problems as children. Silvern and her colleagues caution that witnessing domestic violence may result in traumatic effects on children that are distinct from the effects of child abuse.

Child characteristics

Some findings point to different factors for boys and girls that are associated with witnessing violence. In general, boys have been shown to exhibit more frequent problems and ones that are categorized as external, such as hostility and aggression, while girls generally show evidence of more internalized problems, such as depression and somatic complaints (Carlson, 1991; Stagg, Wills & Howell, 1989). There

are also findings that dissent from this general trend by showing that girls, especially as they get older, also exhibit more aggressive behaviors (for example, Spaccarelli, et al., 1994).

Children of different ages also appear to exhibit differing responses associated with witnessing violence. Children in preschool were reported by mothers to exhibit more problems than other age groups (Hughes, 1988).

Few studies have found differences based on race and ethnicity. O'Keefe's (1994) study of white, Latino, and African-American families of battered women found that all the children were viewed by their mothers as having serious emotional and behavioral problems. The only difference found between the groups was on social competence; African-American mothers rated their children more competent when compared to other mothers' ratings of their own children.

Time since violent event

The longer the period of time since exposure to a violent event the fewer effects a child experiences. For example, Wolfe, Zak, Wilson and Jaffe (1986) found more social problems among children residing in shelters than among children who had at one time in the past been resident in a shelter. The effect of the immediate turmoil may temporarily escalate child problems as observed in a shelter setting.

Parent-child relationship factors

A number of authors have discussed a child's *relationship to adult males* in the home as a key factor. Peled (1996) suggests that children's relationships with their battering fathers were confusing, with children expressing both affection for their fathers and resentment, pain and disappointment over his violent behavior.

Children's *relationships to their mothers* have also been identified as a key factor in how children are affected by witnessing domestic violence. Some have conjectured that a mother's mental health would negatively affect a child's experience of violence but the data are conflicting. Wolfe, Jaffe, Wilson and Zak (1985) found that maternal stress statistically accounted for a large amount of child behavior problems. Another study of child witnesses of violence, however, found that mothers' mental health did not affect a child's response to violence in the home (McClosky et al., 1995).

Family support and *children's perceptions of their parental relationships* have also been identified as key parent-child variables. For example, Durant et al. (1994) found home environments to be important among the 225 urban black adolescents they studied. Adolescents exposed to community and domestic violence appeared to cope better if they lived in more stable and socially connected households.

Research Methods Used to Study Child Witnessing

Interpreting this literature raises several problems based on the research methodologies applied. These include problems with definitions, samples, sources of information, measures, and research designs. Each is reviewed below. While together these flaws raise serious questions about this body of literature, these problems should not cause us to dismiss findings that are consistently replicated across different studies using different methods and samples.

Definitions

A significant problem in this body of literature is that many researchers have failed to differentiate abused children from those who are not themselves abused but who witness family violence. For example, Kolbo (1996) notes that of the 60 child witnesses he studied at a non-shelter domestic violence program all but two were also targets of violence. Some authors do not even identify the degree to which the children studied are both abused and witnessing violence. Rather, they sometimes present their data as representative of children who only witness violence. As Silvern et al. (1995) have stated, "the relationship between reported partner and child abuse should warn that research could be flawed if it is assumed that shelter samples of children have been exposed solely to partner abuse" (p. 195).

Samples

Another issue in this literature is that most studies draw on samples of children and their mothers who

are located in shelters for battered women. While this research generates very important information for shelter-based programs, residing in shelters may be a very stressful point in a child's life and not representative of his or her mental health in the long run. Not only have shelter-resident children most likely witnessed a violent event but they have also been removed from the familiar surroundings of their homes, neighborhoods and often their schools.

Sources of reports

Who reports the child's problems in a study may also skew the information we receive. Almost all of the studies reported above relied on mothers' reports of their children's problems. O'Brien, John, Margolin and Erel (1994) have shown that many parents report their children are unaware of violence between the adults when the children, in fact, report awareness of it. Studies that rely on the reports of only parents to define witnessing may incorrectly classify significant numbers of children as non-witnesses. Studies have also shown that in reports of other forms of maltreatment there are discrepancies between child, parent, clinician and agency ratings of problems. Sternberg, Lamb and Dawud-Noursi (1998) have found that child witnesses of violence and their parents differ significantly on the problems they report to researchers.

Measures

The over-reliance on a single reporter is a theme that is carried through to the measures used in these studies. The reason "internalized" or "externalized" behavior problems are so frequently mentioned in this literature is a direct result of the repeated use of the Child Behavior Checklist as mentioned earlier. Very few investigators have ventured beyond the use of this measure of a few others such as the Trauma Symptoms Checklist and there is not currently a standardized measure developed that addresses the unique problems experienced by children who witness violence at home. Such measures should include an assessment of a child's perceived safety. Other variables not yet measured include disruption in child's social support network among extended family members, school personnel and friends, the safety and effect of visitation arrangements, and the effect of changed economic factors on the child's development.

Design

A final weakness in this area of study is that most studies are correlational. As Holtzworth-Munro, Smutzler and Sandin (1997) point out, these studies only show *associations* between being a witness and some other variable such as a behavior problem. We generally speak of the effects of witnessing violence on children's development. In reality, however, these studies reveal only an association between the variables without predicting that one variable caused the other to occur or vice versa. Many people make the assumption that finding an association is the same as finding that a particular event such as witnessing violence *caused* a child's problems.

Implications

The studies reviewed for this document provide strong evidence that children who witness domestic violence at home also exhibit a variety of behavioral, emotional, cognitive and longer-term developmental problems. Each child will experience adult domestic violence in unique ways depending on a variety of factors that include direct physical abuse of the child, his or her gender and age, the time since exposure to violence, and his or her relationship with adults in the home. Significant percentages of children in the studies reviewed showed no negative developmental problems despite witnessing repeated violence. We must be careful to not assume that witnessing violence automatically leads to negative outcomes for children.

These data are primarily based on samples of children living in shelters for battered women. This has been used as a criticism of these studies on the grounds that shelter residence is a time of crisis and not representative of a child's on-going life. These data do, however, provide shelters with a much better understanding of the problems many of their resident children may be experiencing. And despite the limitations of some individual studies cited, the number and variety of studies so far reported provide a strong basis for accepting the overall findings.

There is a danger that these data may lead some child protection agencies to more frequently

define child witnessing of violence as a form of child abuse or neglect. It is not uncommon to see battered women charged with "failure to protect" their children from a batterer. Many child protection agencies continue to hold battered mothers solely responsible for their children's safety. These actions are often based on the belief that separating from a batterer will always be the safest path for the battered woman and her child.

Yet these actions on the part of the child protection system ignore the reality that the majority of assaults and murders of battered women occur after they have been separated or divorced from their perpetrator. Such actions also ignore the reality that battered mothers often make decisions about their relationships with male partners based on their judgments of what will be best for their children.

The responsibility for creating a dangerous environment should be laid squarely on the shoulders of the adult who is using violent behavior, whether or not that adult is the legal guardian of the child. Responsibility and blame should not be placed on adult survivors in the home. Holding the violent abuser responsible for ending the use of violence is the path that leads to safety for these children and their abused mothers.

It is likely that the outcomes of additional studies on this topic will be reported in the immediate future. The responses to existing and future studies should be to identify ways to provide safety to both children and any abused adults who also reside in their homes.

Author of this document:
Jeffrey L. Edleson, Ph.D.
University of Minnesota
School of Social Work
April 1997 (Revised April 1999)

Recent Reviews of the Literature

Edleson, J. L. (1999). Children's witnessing of adult domestic violence. *Journal of Interpersonal Violence, 14*(8), (Forthcoming August 1999).

Holtzworth-Munroe, A., Smutzler, N., & Sandin, B. (1997). A brief review of the research on husband violence. Part II: The psychological effects of husband violence on battered women and their children. *Aggression and Violent Behavior, 2,* 179-213.

Margolin, G. (1998). Effects of witnessing violence on children. In P. K. Trickett, & C. J. Schellenbach (Eds.), *Violence against children in the family and the community* (pp. 57-101). Washington, DC: American Psychological Association.

Additional References Cited

Achenbach, T. M., & Edelbrock, C. (1983). *Manual for the child behavior checklist and revised child behavior profile.* Burlington, VT: University of Vermont Department of Psychiatry.

Carlson, B. E. (1991). Outcomes of physical abuse and observation of marital violence among adolescents in placement. *Journal of Interpersonal Violence, 6,* 526-534.

DuRant, R. H., Cadenhead, C., Pendergrast, R. A., Slavens, G., & Linder, C. W. (1994). Factors associated with the use of violence among urban Black adolescents. *American Journal of Public Health, 84,* 612-617.

Henning, K., Leitenberg, H., Coffey, P., Turner, T., & Bennett, R. T. (1996). Long-term psychological and social impact of witnessing physical conflict between parents. *Journal of Interpersonal Violence, 11,* 35-51.

Hughes, H. M. (1988). Psychological and behavioral correlates of family violence in child witness and victims. *American Journal of Orthopsychiatry, 58,* 77-90.

Hughes, H. M., Parkinson, D., & Vargo, M. (1989). Witnessing spouse abuse and experiencing physical abuse: A "double whammy"? *Journal of Family Violence, 4,* 197-209.

Jaffe, P., Wilson, S., & Wolfe, D. E. (1986). Promoting changes in attitudes and understanding of conflict resolution among child witnesses of family violence. *Canadian Journal of Behavioral Science, 18,* 356-366.

Kolbo, J. R. (1996). Risk and resilience among children exposed to family violence. *Violence & Victims, 11,* 113-128.

Mathias, J. L., Mertin, P., & Murray, A. (1995). The psychological functioning of children from backgrounds of domestic violence. *Australian Psychologist, 30,* 47-56.

McClosky, L. A., Figueredo, A. J., & Koss, M. P. (1995). The effects of systemic family violence on children's mental health. *Child Development, 66,* 1239-1261.

O'Brien, M., John, R. S., Margolin, G., & Erel, O. (1994). Reliability and diagnostic efficacy of parents' reports regarding children's exposure to marital aggression. *Violenceand Victims, 9,* 45-62.

O'Keefe, M. (1994). Linking marital violence, mother-child/father-child aggression, and child behavior problems. *Journal of Family Violence, 9,* 63-78.

Peled, E. (1996). Supporting the parenting of battering men: Issues and dilemmas. Manuscript submitted for publication.

Rossman, B. B. (1998). Descartes's error and post-traumatic stress disorder: Cognition and emotion in children who are exposed to parental violence. In G.W. Holden, R. Geffner, & E. N. Jouriles (Eds.), *Children exposed to marital violence* (pp. 223-256). Washington, DC: American Psychological Association.

Silvern, L., Karyl, J., Waelde, L., Hodges, W. F., Starek, J., Heidt, E., & Min, K. (1995). Retrospective reports of parental partner abuse: Relationships to depression, trauma symptoms and self-esteem among college students. *Journal of Family Violence, 10,*177-202.

Singer, M. I., Miller, D. B., Guo, S., Slovak, K., & Frierson, T. (1998). *The mental health consequences of children's exposure to violence.* Cleveland, OH: Cayahoga County Community Mental Health Research Institute, Mandel School of Applied Social Sciences, Case Western Reserve University.

Song, L., Singer, M., & Anglin, T. (1998). Violence exposure and emotional trauma as contributors to adolescents' violent behaviors. *Archives of Pediatric and Adolescent Medicine, 152,* 531-536.

Spaccarelli, S., Coatsworth, J. D., & Bowden, B. S. (1995). Exposure to serious family violence among incarcerated boys: Its association with violent offending and potential mediating variables. *Violence and Victims, 10,* 163-182.

Stagg, V., Wills, G. D., & Howell, M. (1989). Psychopathology in early childhood witnesses of family violence. *Topics in Early Childhood Special Education, 9,* 73-87.

Sternberg, K. J., Lamb, M. E., & Dawud-Noursi, S. (1998). Using multiple informants to understand domestic violence and its effects. In G. W. Holden, R. Geffner, & E. N. Jouriles (Eds.), *Children exposed to marital violence* (pp. 121-156). Washington, DC: American Psychological Association.

Wolfe, D. A., Jaffe, P., Wilson, S. K., & Zak, L. (1985). Children of battered women: The relation of child behavior to family violence and maternal stress. *Journal of Consulting and Clinical Psychology, 53,* 657-665.

Wolfe, D. A., Zak, L., Wilson, S., & Jaffe, P. (1986). Child witnesses to violence between parents: Critical issues in behavioral and social adjustment. *Journal of Abnormal Child Psychology, 14,* 95-104.

On-Line Resources

Bibliography on "Children Who Witness Violence: Research & Intervention" by Jeffrey L. Edleson at *http://www.mincava.umn.edu/bibs/bibkids.htm*

Bibliography from the Project to Address Violence through Education (PAVE) at the University of Minnesota on "Young children and violence" at *http://www.cyfc.umn.edu/pave/preview.htm*

Mothers & Children: Understanding the Links Between Woman Battering and Child Abuse is a briefing paper by Jeffrey L. Edleson for a recent strategic planning meeting on the Violence Against Women Act at *http://www.mincava.umn.edu/papers/nij.htm*

In the Best Interest of Women and Children: A Call for Collaboration Between ChildWelfare and Domestic Violence Constituencies is a briefing paper by Susan Schechter and Jeffrey L. Edleson prepared for a Wingspread Conference of a similar title and can be found at *http://www.mincava.umn.edu/papers/wingsp.htm*

Child Witness to Domestic Violence is a brief paper written by Kathryn Conroy, DSW, on the effect on children of witnessing their mothers being battered at *http://www.columbia.edu/~rhm5/CHDWITDV.html*

Children and Family Violence: The Unnoticed Victims is a May 1994 report by Gabrielle M. Maxwell of New Zealand's Office of the Commissioner for Children at *http://www.mincava.umn.edu/papers/nzreport.htm*

An art gallery from the Domestic Abuse Project in Minneapolis of 13 images drawn by children who have witnessed violence at *http://www.mincava.umn.edu/kart.asp*

VAWnet is a project of the National Resource Center on Domestic Violence
800-537-2238 TTY 800-553-2508 Fax 717-545-9456

U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

OJJDP
Shay Bilchik, Administrator
March 1997
JUVENILE JUSTICE BULLETIN

Child Development–Community Policing: Partnership in a Climate of Violence

Steven Marans, M.S.W., Ph.D.
Miriam Berkman, J.D., M.S.W.

The New Haven Department of Police Services and the Child Study Center at the Yale University School of Medicine have developed a unique collaborative program to address the psychological impact of the chronic exposure to community violence on children and families. The Child Development–Community Policing (CD–CP) program brings police officers and mental health professionals together to provide each other with training, consultation, and support, and to provide direct interdisciplinary intervention to children who are victims, witnesses, or perpetrators of violent crime. The New Haven program serves as a national model for police-mental health partnerships across the country.

Children's Exposure to Violence

The experience of victimization by violence is far too common among children in America, as evidenced below:

- In 1994, almost 2.6 million youth ages 12 to 17 were victims of crime—simple and aggravated assaults, rape, and robbery (Bureau of Justice Statistics, "National Crime Victimization Survey." Unpublished table.).
- In 1994, an estimated 3.1 million children were reported to public welfare agencies for abuse or neglect. More than 1 million of those children were substantiated as victims (Wiese and Dara, 1995).
- Homicide is the leading cause of death among African American males ages 15 to 24 (Hawkins, Crosby, and Hammett, 1994).
- A survey of inner-city high school students revealed that 45 percent had been threatened with a gun, or shot at, and one in three had been beaten up on their way to school (Sheley and Wright, 1993).

In addition, an alarming number of children who are not the direct victims of physical assault become potential psychological casualties as they witness violence both at home and in the broader community. For example:

- In a study conducted at Boston City Hospital, 1 out of every 10 children seen in their primary care clinic had witnessed a shooting or a stabbing before the age of 6—50 percent in the home and 50 percent in the streets. The average age of these children was 2.7 years (Taylor et al., 1992).
- In a study of New Haven 6th, 8th, and 10th grade students, 40 percent reported witnessing at least one violent crime in the previous year (New Haven Public Schools, 1992).
- In a survey of fifth and sixth grade students in Washington, D.C., 31 percent reported having witnessed a shooting;

From the Administrator

Too many of our Nation's children are falling victim to pervasive violence. Even young people who do not bear the physical scars of domestic and societal violence are often emotional casualties.

The tragic consequences to children of chronic exposure to violence are considerable. They include depression, anxiety, stress, and anger. Alcohol abuse, academic failure, and the increased likelihood of acting out in a violent manner are part of the costly legacy left by a climate of violence.

With the support of the Office of Juvenile Justice and Delinquency Prevention, the New Haven Department of Police Services and the Yale University Child Study Center have established a program that addresses the adverse impact of continuing exposure to violence on children and their families, and attempts to interrupt the cycle of violence impacting so many of our children.

Reflecting New Haven's commendable commitment to community policing, the Child Development–Community Policing Program brings law enforcement and mental health professionals together to help children who are victims, witnesses, and even perpetrators of violent acts.

I am pleased to present this promising model of professional partnership for your consideration.

Shay Bilchik
Administrator

BEST COPY AVAILABLE

17 percent had witnessed a murder; and 23 percent had seen a dead body (Richters and Martinez, 1993).

- Among males in some high schools as many as 21 percent reported seeing a person sexually assaulted; 82 percent had witnessed a beating or mugging in school; 46 percent had seen a person attacked or stabbed with a knife; and 62 percent had witnessed a shooting (Singer et al., 1995).

Children's exposure to violence and maltreatment is significantly associated with increased depression, anxiety, post traumatic stress, anger, greater alcohol use, and lower school attainment (Garbarino et al., 1992; Martinez and Richters, 1993; Singer et al., 1995; Cicchetti and Carlson, 1989).

Richters and Martinez (1993) produced substantial evidence that parents tend to significantly underestimate their children's exposure to community violence as well as associated stress symptoms. Recognition of and verbal dialog regarding children's experience with violent events were seen as the most likely ways to mitigate the formation of stress symptoms.

Youth who are repeatedly exposed to multiple risk factors—for example, socially isolated, impoverished, violence-ridden neighborhoods—require the most "intensive integrated, sustained, coordinated, and comprehensive intervention" according to the recommendations of a consensus of professionals in the field (Carnegie Council on Adolescent Development, 1992a; Citizens Committee for Children, 1993; Greene, 1996; Palmer, 1983; Schorr, 1989).

In addition, as indicated by the following figures, children who experience violence either as victims or as witnesses are at increased risk of becoming violent themselves:

- In an OJJDP-funded study of children in Rochester, New York, children who had been victims of violence within their families were 24 percent more likely to report violent behavior as adolescents than those who had not been maltreated in childhood. Adolescents who were not themselves victimized but who had grown up in families where partner violence occurred were 21 percent more likely to report violent delinquency than those not so exposed. Overall, children exposed to multiple forms of family violence reported twice the rate of youth violence as those from nonviolent families (Thornberry, 1994).
- In a survey of 30 incarcerated delinquent adolescents in Connecticut, 83 percent reported previously witnessing a shooting, 67 percent reported witnessing a stabbing, and 53 percent reported witnessing a killing. Sixty-three percent of the respondents reported having been shot at and 50 percent reported having been stabbed (Vitulano et al., 1996).
- In a survey of New York City's juvenile detention facility, 79 percent had seen a person stabbed or shot; 58 percent had a family member who had been shot or stabbed; and 38 percent had been shot or stabbed themselves (City of New York, 1993).

These children are of particular concern to law enforcement as they perpetuate the cycle of violence into the next generation.

Police officers, as the first responders on scenes of violence and tragedy, have frequent contact with the children and families most at risk as a result of their exposure to violence. However, officers ordinarily do not have the training, the practical support, or the time to deal effectively with the psychological aftermath of children's experiences with violence. While mental health professionals may be equipped to intervene to ameliorate the psychological consequences of children's exposure to violence, traditional, clinic-based therapists often have no opportunity to treat these children until months or years later, when they are presented with entrenched symptoms such as school failure or dangerous, disruptive, and violent behavior. The CD–CP program, developed in New Haven, Connecticut, brings police and mental health professionals together to develop new, collaborative approaches to problems that are beyond the reach of either profession when working in isolation. This opportunity is especially clear in the context of the New Haven model of community policing, which places officers on permanent assignment in neighborhoods, expands their role in building relationships with community residents, and encourages their regular contact with children and families in a range of nonconfrontational settings.

Community Police Responses

At best, police can provide children and families with a sense of security and safety through rapid, authoritative, and effective responses at times of danger. Often, however, children's contacts with police officers arouse more negative feelings. For example, the arrival of officers after a violent event can reinforce a child's sense of being unprotected and the feeling that those in charge provide too little, too late. For many children, particularly those in impoverished inner cities, the police are seen as representatives of a dominant, insensitive culture and quickly become targets of children's anger toward a hostile and uncaring society.

Community policing provides officers with opportunities to minimize these negative experiences and instead offer children positive models for identification. Police officers who take on a consistent, authoritative presence in their neighborhoods are potential heroes for young people for whom there are all too few prosocial adult models. As community policing places individual officers on long-term assignments in specific neighborhoods and encourages them to work with community residents to analyze and solve problems before they erupt in lethal violence, children and families come in contact with officers in a wide variety of helping roles well beyond the context of such traditional police functions as making arrests or executing search warrants. As community policing integrates officers within their communities they become known as individuals, rather than by role, and they come to know the people they serve as individuals. These strategies allow officers to develop relationships and assume roles in children's lives that would not be possible in a more impersonal, incident-driven policing system.

For example, following a child's exposure to a serious incident of violence, regular contact with a familiar beat officer can serve to increase the child's sense of security, provide a prosocial adult model for identification, and support the child's family to obtain needed mental health or other social services. Similarly, regular, nonconfrontational contact with a neighborhood officer may help some young delinquents to control their impulses to engage in criminal activity and to abide by court-imposed restrictions. As figures of authority, police officers are also in a position to broker services for families

BEST COPY AVAILABLE

and to coordinate the responses of other institutions. The assumption of such expanded roles in the lives of children also imposes new burdens on police officers and requires new modes of training and operational support.

The CD–CP program reflects and contributes to a more general change in the approach to policing in New Haven. In this model of community policing, the establishment and maintenance of relationships between community-based officers and community residents is of central importance. As New Haven officers have become part of the social landscape of the neighborhoods they serve, they no longer represent an anonymous target for the pent-up frustration and rage felt by underserved and disadvantaged community residents. Consequently, both the physical risk to officers and officers' feelings of apprehension in the community have diminished.

The central focus on relationships between police and community members has also resulted in other markers of law enforcement success. When officers know the community, they recognize that the majority of citizens are law abiding and represent potential partners for a better neighborhood. This frees officers to focus more effective enforcement efforts on the small number of career and violent offenders. For example, after the 1991 inception of community-based policing in New Haven, four major drug gangs were targeted by a joint Federal/State task force on drug enforcement. Relationships between community patrol officers and residents in neighborhoods most affected by drugs and associated violence led to extensive intelligence that was invaluable to the effective Federal prosecution and long-term incarceration of high-level leaders in all four gangs. Similarly, the New Haven police focus on personal relationships as the core of community policing has resulted in a 95-percent closure rate of all homicide investigations.

Collaborative Responses

The CD–CP program is a partnership that developed out of the shared concerns of New Haven police and mental health professionals regarding the experiences of children and adolescents exposed to and involved in community violence. The program aims to coordinate the efforts of community police officers and mental health clinicians to reduce the psychological burdens of violence on children and families, community members, and mental health professionals themselves. The CD–CP program is closely related to and dependent on the reorientation of the New Haven police to a community-based policing philosophy. Through the application of principles of child development and human functioning to the daily work of neighborhood police officers, the program provides officers with an expanded frame of reference and more varied options for intervening in the lives of children and families exposed to violence. Similarly, through a reorientation of the traditional relationships between mental health clinicians and police professionals, the program extends the roles that mental health clinicians play in the lives of the same children and families (Marans and Cohen, 1993; Marans et al., 1995; Marans, Berkman, and Cohen, 1996).

The CD–CP program has become a foundation for officers to broaden their roles as problem solvers. The process of consultation and collaboration with mental health and allied professionals breaks down barriers to the idea that complex problems require multiple solutions that involve new partners. As the burden and problem-solving tasks are shared, officers experience a greater sense of effectiveness and are increasingly able to sustain their engagement in the lives of children. When problems can be assessed in the context of the CD–CP partnership, intervention can not only take place in a more timely fashion but also without the fragmentation of services that so often leads to a squandering of limited resources.

Program Outline

The CD–CP program model consists of interrelated training and consultative components that aim at sharing knowledge and developing ongoing collegial relationships between police officers and mental health professionals.

1. Child Development Fellowships for Police Supervisors

Child Development Fellowships help provide supervisory officers with the special psychological expertise they need to lead a cohesive team of community-based officers in a wide variety of crime prevention, early intervention, and relationship-building activities involving children, families, and community agencies in their individual neighborhoods. Child Development Fellows spend 3 to 4 hours per week over the course of 3 to 4 months in the Child Study Center. Fellows participate in a range of activities and observations that familiarize them with developmental concepts, patterns of psychological disturbance, methods of clinical intervention, and settings for treatment and care. Police supervisors involved in the fellowship also provide basic knowledge about police practice to their mental health colleagues. A major goal of the fellowship is to establish relationships between the fellows and the child mental health professionals with whom they will be collaborating in the future.

2. Police Fellowships for Clinicians

The Police Fellowship provides clinicians with opportunities to spend time with police colleagues in squad cars, in police stations, and in the streets observing and learning directly from officers about their day-to-day activities. This exposure assists clinicians in understanding the environment to which children and families are exposed, the relationships between members of the community and the police, and the various uses of police authority in daily interactions with community residents. Observing the realities of officers' interactions with children provides a framework for understanding the roles that officers play in the psychological lives of children and families and prepares mental health professionals to intervene collaboratively with police partners in cases referred through the consultation service. Extended contact with police colleagues through the fellowship also provides the basis for trust in the ongoing working relationships on which the program depends.

3. Seminar on Child Development, Human Functioning, and Policing Strategies

The CD–CP seminar on child development, human functioning, and policing strategies is a course for police officers, mental health clinicians, and related professionals (e.g., probation officers) that is co-led by a team of clinical faculty members and a police supervisor experienced in the CD–CP program. The seminar meets each week for 1.5 hours over a period of 10 weeks. Using case scenarios drawn from the experiences of the seminar members and group leaders, the seminar applies principles of child development to the daily work of police officers to provide officers and clinicians with knowledge and a sense of personal empowerment to intervene positively with

BEST COPY AVAILABLE

children and families. Exposure to developmental principles introduces officers to the importance of thinking about children's development and their own influence on children. Exposure to police perspectives on children, families, violence, and crime expands clinicians' understanding of the children they work with and the role of legal authority in containing children's responses to violence.

4. Consultation Service

As community-based police officers become more active and visible within their neighborhoods, they establish more frequent contact with children and families who are in danger or distress, including victims or witnesses of violence, truants from school, and teens involved with gang activity. These neighborhood officers need a resource to turn to for discussion, guidance, and an immediate clinical response, especially when the child is in great distress, as happens so often following exposure to serious violence. The CD–CP consultation service allows police officers to make referrals and to obtain immediate clinical guidance, especially in the aftermath of children's traumatic experiences. Consultation service clinicians and police supervisors experienced in the program are on call 24 hours a day to discuss difficult situations involving children and adolescents. When a direct clinical response is necessitated by the urgency of a child's distress (e.g., a child who has just witnessed the murder of a relative), a clinician will respond immediately and may see the child and family at the clinic, the police station, or the child's home. Less urgent clinical meetings, referrals to other services, coordination with other agencies, and regular followup by both police and clinicians are also arranged.

5. Program Conference

Police officers and clinicians who staff the CD–CP program meet weekly to discuss difficult and perplexing cases that arise from officers' direct experiences in their neighborhoods and from the consultation service. The case discussions provide a forum for police, clinicians, and allied professionals to examine cases from a variety of perspectives in order to understand better the experience of children and families exposed to violence, to explore the limits of current intervention strategies, and to develop improved methods of collaboration and response. The conference also provides a regular forum for planning and evaluation of program activities and for examining systemic, institutional, and administrative issues. Police supervisors representing all sectors of the city participate in the program conference and bring to the discussion the various concerns of community residents in their districts.

Juvenile Justice Response

Many of the children and adolescents about whom police officers and clinicians are most concerned are those who have experienced chronic exposure to violence and who are now becoming involved in delinquent activities. To respond to these children and adolescents, the CD–CP collaboration has expanded to include representatives of the juvenile justice system. In addition, the team's approaches to intervention with this group of children have expanded the use of legal authority to provide external structure where internal and family structures are lacking.

As a result of the placement of juvenile probation officers in several New Haven neighborhoods, with offices in the local community substations, police officers, clinicians, and juvenile probation officers have more closely coordinated their work with young delinquents. In this context, the CD–CP training and weekly conference has provided a central forum for examining comprehensive approaches to programmatic innovation as well as case planning for individual juveniles. As a result of this planning process, neighborhood police officers and juvenile probation officers collaborate in the supervision of young offenders by regularly sharing information about children and adolescents on probation and assigning police officers to supervise some community service projects. In addition, CD–CP clinicians provide regular consultation to juvenile probation officers and the local juvenile detention center regarding the mental health needs of children and adolescents involved in the juvenile justice system.

Results of the CD–CP Program's First 5 Years

The expected outcomes of the CD–CP program can be generally stated as broadening the frames of references that govern the work of the police, mental health professionals, and additional collaborators and that contribute to an increasing array of coordinated responses to the witnesses of community violence and to youth involved in the perpetration of violence and other gateway criminal activities that may involve or lead to violent crimes. These outcomes may be indicated by:

1. Organizational changes in the provision of police and mental health services.
2. Development of protocols and procedures for responding to youth exposed to or involved in violent and other at-risk, criminal activities
3. An increase in the number of cases in which consultation and coordinated interventions occur.
4. An increase in the number of collaborations with schools, child welfare, probation, etc., for primary prevention and intervention.
5. Police officers' greater knowledge of the experience of children and greater appreciation for the potential benefits of collaborative intervention.
6. Clinicians' increased knowledge of policing strategies and practices and greater appreciation of the potential therapeutic value of police authority.
7. Implementation of a protocol for regular tracking and monitoring of children referred to the consultation service across a variety of domains, including exposure to additional violent incidents, involvement in delinquent activities, and experience of post-traumatic symptoms.

Training

Since the CD–CP program began formal operation in January 1992, the entire department has received orientation and training regarding program goals and utilization of on-call and referral services; a range of inservice training related to CD–CP principles and practice has been presented; approximately 250 officers have completed the 10-week CD–CP seminar; the assistant chief of police and 39 supervisory sergeants and lieutenants have completed the Child Development Fellowship and continue to attend the weekly Program Conference; 8 Child Study Center faculty members have completed the Police Fellowship; and an elective for mental health professionals in training has been developed.

Referrals and Consultations

The Consultation Service has received approximately 350 referrals regarding

BEST COPY AVAILABLE

more than 600 children. Calls to the Consultation Service have concerned children of all ages who have been involved in a variety of violent incidents as victims, witnesses, or perpetrators, both in their families and in the larger community. Children who have been referred have been seen both individually and in groups in their homes, police stations, hospitals, schools, and the Child Study Center. In addition, formal protocols have been developed regarding such practices as notification of the Consultation Service in critical incidents involving children as victims, witnesses, or perpetrators; distribution of informational pamphlets describing the psychological impact on children of their exposure to violence and the availability of assistance through the CD–CP program; and routine followup by neighborhood officers to ensure the security and stability of families exposed to violence.

The results of the CD–CP program can also be seen in the following representative examples of cases referred by police to the Consultation Service:

- A mother and two children, ages 2 and 10, were present when a relative was shot to death through the door of their apartment. The district supervisor, a CD–CP fellow, offered a referral for mental health services and also provided the mother with his beeper number. The supervisory sergeant accepted daily calls from the mother, during which he provided her with information regarding the family's protection from reprisal and reminded her that clinical support was available. With the ongoing support of the sergeant, the mother was able to accept the mental health referral for herself and her children. After intensive treatment, both children are functioning well in school and the mother was able to relocate her family to a safer neighborhood.
- A woman was stabbed to death by her estranged boyfriend in the presence of her eight children. CD–CP clinicians responded to the scene, provided acute clinical assessments of the children, and consulted with relatives and police as to how to tell the children their mother was dead. Police conducted followup visits to the family, providing practical recommendations for the security of the home and information regarding the status of the prosecution. The efforts of police, mental health, child welfare, and home-based support professionals, coordinated by the CD–CP team, allowed the children to remain together rather than be dispersed to multiple foster homes. CD–CP clinicians evaluated each of the children and engaged several members of the family in long-term psychotherapy. All of the children are currently attending school. Symptoms of anxiety, depression, and aggressive behavior have diminished.
- A 15-year-old boy was robbed at gunpoint by two men. In the immediate aftermath of the robbery, he was too shaken to say anything to police about what had happened. Officers referred him for an urgent clinical evaluation, which took place at the local hospital. During the course of the clinical interview, the boy reported wanting to get a gun and take revenge. By the end of the interview, however, he had recovered sufficient memory of the events to become an effective aid to investigating detectives, who were then able to arrest the robbers. Local community-based officers established regular contact with the boy, supporting him in the maintenance of his good school record and deterring an early-stage involvement with neighborhood drug dealers.
- A 14-year-old boy was involved in leading a group of other teens in a series of beatings and criminal mischief that terrorized his neighborhood. Although police officers were aware of his activities, they were unable to obtain sufficient evidence to arrest him. CD–CP officers and clinicians convened a series of meetings regarding community safety, which were attended by local officers, school officials, juvenile probation, clinical consultants, and community leaders. As a result of the meetings, police obtained more effective cooperation from the community and eventually arrested the boy. The CD–CP program conference provided a forum for case planning, and the collaborative group recommended close probation supervision to the court. Under strict supervision, the boy's criminal activities were curtailed, and he returned to school. Throughout his probation, police and probation officers maintained close contact to monitor his behavior.
- A 12-year-old boy was arrested 8 times for auto theft. He had been truant from school more days than not over a 2-year period. When the boy's cases were finally adjudicated, he was referred to a pilot project, developed and coordinated by the CD–CP program, in which strict probation supervision is supplemented by community service, home-based case management, recreational activities, and group therapy. The boy returned to school and has not been rearrested in 4 months. Friends from his neighborhood ask to come with him to group activities.
- Following the shooting death of a 17-year-old gang member, there was good reason for concern about retaliation and further bloodshed. In the days that followed the death, grieving gang members congregated on the corner where the shooting had taken place. Efforts at increased presence and containment took the form of police, neighborhood-based probation officers, and clinicians spending time on the corner listening to gang members' express their grief. As one senior police officer put it, "We could show our concern for their trauma by being with them, lending an adult ear to their misery. Alternatively, we could put more officers on the street, show them who's boss, and with a show of force, sweep them off the corner as often as necessary. . . .We could then offer them an additional enemy and wait for them to explode." At this crucial moment, the police did not assume the role of enemy. They did not serve as a target for displaced rage or, in confrontation, offer an easy antidote to sadness and helplessness. Rather than exacting "payback" in blood, the typical gang response, the gang discreetly assisted the police in making a swift arrest in the shooting. As one gang member, the brother of the victim, put it to a neighborhood cop, "You were there for us; that helped. . . ."

Juvenile Justice Responses

Because of their powerful and positive experience with the addition of juvenile probation to the CD–CP program, the group has also developed a pilot intervention project that applies the program's collaborative principles to community-based work with adolescents who are beginning to engage in delinquent activities. This Gateway Offenders Program brings together community-based police officers, community-based probation officers, CD–CP clinicians, school officials, and case managers to provide coordinated, comprehensive, and structured

BEST COPY AVAILABLE

assessment and intervention for a small group of juvenile offenders who are at high risk of escalating criminal involvement and removal from the community. Probation and police officers provide the external authority necessary to contain program participants through intensive supervision, frequent monitoring, and the imposition of variable sanctions for violations. In close collaboration with these figures of authority, clinicians, educators, and case managers provide a range of educational, therapeutic, and recreational interventions, including life skills and conflict resolution training, community service projects, afterschool activities, wilderness experiences, group psychotherapy, and coordination with participants' parents. In this context, clinical evaluations and treatment are not seen as an alternative to judicial action but as part of a coordinated response. In the first 4 months of the project, only 1 of 15 participants has been rearrested for new criminal behavior (Juvenile Services Unit, New Haven Department of Police Services).

Since the implementation of the CD–CP program, there have been significant changes in police approaches to juvenile delinquency and corresponding changes in results. Based on community officers' familiarity with New Haven neighborhoods and the coordination of their efforts with community-based juvenile probation officers, there are no outstanding warrants for the arrest of juveniles in New Haven (Juvenile Probation Division, New Haven County). In addition, while New Haven currently refers twice the number of juvenile offenders to the juvenile justice system, it sends only half the number of juveniles to correctional facilities as Hartford, and three times fewer than Bridgeport. This suggests that, in the community in which the collaboration was developed, alternatives to incarceration have increased significantly.

Truancy Intervention

The CD–CP program has also had an impact on rates of truancy in New Haven. As an outgrowth of the police-mental health collaboration, police have increased their involvement with the New Haven public schools. Teams of community-based officers and dropout prevention workers canvass New Haven neighborhoods during school hours, approaching suspected truants, identifying them, taking them to school, and contacting school personnel and parents about their attendance and other school-related problems (e.g., fighting, drug or gang involvement, etc.). Responding to reports from the daytime team, evening shift officers follow up with visits to the children's homes, discussing truancy issues with both the student and his or her parents. For many parents, these visits mark the first time that they become fully aware of the extent of a child's truancy. The first visit is followed by others if the student continues to miss school and contingencies are developed with parents, school officials, mental health professionals, probation officers, and social service workers who are already involved or may need to be involved with the youngster and his or her family. With a mixture of authority, psychological sophistication, and persistence, officers involved in the truancy reduction efforts have been enormously successful. In the first 6 months of operation, the truancy initiative accounted for a reduction of 20,000 unexcused absences. In one urban middle school, daily unexcused absences have decreased from more than 120 to fewer than 70 (New Haven Schools). It is anticipated that the decrease in truancy will, in turn, result in a reduction in criminal activity in New Haven, where police have estimated that juveniles were responsible for 60 percent of auto thefts (Juvenile Services Unit, New Haven Department of Police Services).

Program Evaluation Research

The nature of the collaboration, and the clinical, consultative, and specialized police work that occurs within the collaboration, is a challenge to document reliably and consistently. CD–CP research staff have developed a comprehensive electronic case and activity recording system that is the centerpiece of data collection. This system allows program personnel to enter detailed information describing the nature of each case and the response to that case, information regarding the event and the roles of children with regard to that event (e.g., witness, victim, perpetrator, etc.), characteristics of the home and school of children served, diagnostic and evaluation data, intervention data, functional outcome measurement, and other clinical and police activities. An intervie protocol has been developed for a retr spective study of children seen in the first 4 years of the consultation service, which will investigate children's general developmental status, posttraumatic responses, exposure to additional episodes of violence, and subjective experience of the CD–CP intervention. In addition, surveys have been developed to measure changes in the attitudes and practices of police officers and mental health professionals as a result of their involvement in the collaborative program.

Program Replication

The CD–CP program is a national model that is now being replicated under an OJJDP grant in four cities: Buffalo, New York; Charlotte, North Carolina; Nashville, Tennessee; and Portland, Oregon. Additional, privately funded program replication efforts are under way in Baltimore, Maryland; Framingham, Massachusetts; and Newark, New Jersey. A CD–CP program manual, *The Police Mental Health Partnership: A Community-Based Response to Urban Violence* (Marans et al., 1995), has also been developed with OJJDP support.

The Program Replication Process

While each police-mental health partnership will develop its own unique attributes based on the specific needs and resources of the community in which it operates, the CD–CP program model assumes that each new collaborative program will adopt the basic program elements described in this bulletin. CD–CP program staff have been intensively involved in providing training, consultation, and technical assistance to developing programs. The following points highlight the requirements for effective implementation of the program model, based on the experience of the program's developers.

1. Institutional Investment

Because the CD–CP program seeks to achieve fundamental change in the operations and the climate of the police department and a collaborating mental health agency, the leadership of both institutions must commit themselves to a process of questioning and modifying traditional practices and be prepared to support their respective staffs in the implementation of collaborative approaches to intervention with children and families exposed to and involved in violence in their community. Issues of time, money, staffing, program expectations, and evaluation should be identified and addressed at the outset. In many of the communities currently involved in the replication project, a single sector of the city has been selected to begin a program pilot.

66 BEST COPY AVAILABLE

2. *Participating Police Department*

The CD–CP program model builds on the philosophy of community policing and therefore requires that the participating police department have implemented community policing strategies or be engaged in the process of their implementing, particularly with regard to children, adolescents, and families. The program also requires that the policing agency be committed to (a) allowing sufficient time for supervisors and rank and file officers to participate in CD–CP training (approximately 15–20 hours for each seminar and 40 hours for CD–CP Fellowship training); (b) allowing time for supervisors centrally involved in the program to act as seminar leaders and to maintain participation in a weekly program conference; and (c) providing observation and training experiences for mental health professionals involved in the program (e.g., ride alongs, short courses in policing practice).

3. *Participating Mental Health Agency*

The CD–CP program requires a mental health collaborator with staff who are (a) experienced in the evaluation and treatment of children, adolescents, and families, including individuals exposed to criminal violence and other traumatic events; and (b) experienced in teaching and training other professionals in child development principles. The program requires the mental health agency to provide opportunities for police officers to observe children in different clinical settings. The mental health institution also must provide partial salary support for participating staff (three or four clinicians to start) to spend sufficient time observing and meeting with police colleagues, responding to emergency calls from the police for consultation, and co-leading the CD–CP seminar. Funding is not required for ongoing mental health treatment; public benefits, private insurance and/or out-of-pocket payment should be available.

4. *Other Participating Institutions*

Developing collaborative programs may wish to include other institutions that are centrally involved in addressing the needs of children and families exposed to violence such as juvenile probation, schools, or child welfare agencies. In considering expansion of the CD–CP model, program developers should take into account both the benefits to be derived from a broader coordination and the difficulties associated with developing and maintaining a more complex set of institutional and personal relationships.

5. *Training, Consultation, and Technical Assistance for Developing Programs*

Staff of the New Haven CD–CP program are available to provide a program of training and technical assistance to developing programs. Consultation begins with the heads of the participating agencies developing clear goals for the collaborative program. Agency leaders then identify a small working group of community policing supervisors and mental health clinicians who will be responsible for implementing the police-mental health collaboration in their community and who will work closely with the CD–CP consultants. Members of the working group attend a series of intensive meetings and observations, co-led by New Haven police supervisors and Child Study Center clinicians. These meetings provide a comprehensive introduction to the CD–CP program and a forum for considering the steps needed to adapt and implement the program in each replication site. Following the New Haven-based training and consultation meetings, CD–CP consultants provide ongoing on- and off-site technical assistance to guide and support the developing new programs. In addition, CD–CP consultants teach and implement procedures for standardized data collection that serve the program evaluation research. A national network of CD–CP programs facilitates sharing information about the process and results of the interdisciplinary collaboration through conferences, newsletters, and other means.

6. *Program Evaluation Research*

To facilitate consistent data collection across the replication sites and to permit comparisons among the sites, CD–CP consultants will provide personnel in each developing program with copies of the data collection software and survey instruments designed to evaluate the collaborative program (described above). CD–CP staff will provide technical assistance in implementing the data collection and will analyze and report survey results.

One of the fundamental goals of the CD–CP program is to broaden and shift the perspective of officers and clinicians participating in the collaboration. It is believed that officers develop greater knowledge of child development, insight into psychological contributions to human behavior and the implications for policing, a capacity to reflect on and consider a broader range of options, an awareness of the experience of children, an understanding of and favorable attitude toward mental health personnel, and the merits of interventions that emphasize structure, authority, and/or clinical service. Similarly, it is believed that clinicians acquire knowledge of policing and a greater appreciation for the role of police officers in development and therapeutic intervention, the therapeutic value of structure, and the value of mental health consultation to law enforcement. It is changes of this sort that make collaboration possible and presumably result in benefits to children and families in the community. In order to evaluate these changes, CD–CP staff have developed two surveys that provide a comprehensive assessment of officer and clinician knowledge, attitudes, and assumptions as noted above as well as overall satisfaction with the program. Administration of the surveys in the replication sites will allow the program evaluators to follow the development of officers and clinicians over time within each site and also to compare across replication sites. Additional measures of program replication outcome in the various sites will include changes in policing and mental health protocols, numbers of referrals, attendance at collaborative meetings, participation in collaborative training seminars, and outcome measurements related to the children served.

Further information about the CD–CP program can be obtained from:

Colleen Vadala, Administrative Assistant
Child Development–Community Policing Program
Yale Child Study Center
47 College Street, Suite 212
New Haven, CT 06510
203–785–7047

OR

Bob Hubbard, Program Manager
Office of Juvenile Justice and Delinquency Prevention
U.S. Department of Justice
633 Indiana Avenue NW., Room 707
Washington, DC 20531
202–616–3567

References

Bureau of Justice Statistics. "National Crime Victimization Survey." Washington, DC: Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice. Unpublished table.

Carnegie Council on Adolescent Development. 1992. *A Matter of Time.* Woodlawn, MD: Wolk Press.

67 BEST COPY AVAILABLE

Cicchetti, D., and V. Carlson. 1989. *Child Maltreatment: Theory and Research on the Causes and Consequences of Child Abuse and Neglect.* New York, NY: Cambridge University Press.

Citizens' Committee for Children. 1993. *Keeping Track of New York's Children.* New York, NY: Citizens' Committee for Children.

City of New York. 1993 (August). Juvenile detention alternatives initiative.

Garbarino, J., N. Dubrow, K. Kostelny, and C. Pardo. 1992. *Children in Danger: Coping With the Consequences of Community Violence.* San Francisco, CA: Jossey-Bass.

Greene, M.B. 1993. Chronic exposure to violence and poverty: Interventions that work for youth. *Crime and Delinquency* 39(1):106–124.

Hawkins, D.F., A.E. Crosby, and M. Hammett. 1994. Homicide, Suicide and Assaultive Violence: The Impact of Intentional Injury on the Health of African Americans. In L.L. Livingston, ed. *Handbook of Black American Health: The Mosaic of Conditions, Issues, Policies and Prospects.* Westport, CT: Greenwood Press.

Marans, S., et al. 1995. *The Police Mental Health Partnership: A Community-Based Response to Urban Violence.* New Haven, CT: Yale University Press.

Marans, S., and D. Cohen. 1993. Children and Inner-City Violence: Strategies for Intervention. In L. Leavitt and N. Fox, eds. *The Psychological Effects of War and Violence on Children.* Hillsdale, NJ: Lawrence Erlbaum Associates.

Marans, S., M. Berkman, and D. Cohen. 1996. Child Development and Adaptation to Catastrophic Circumstances. In *Minefields in Their Hearts: The Mental Health of Children in War and Communal Violence.* R. Apfel and B. Simon, eds. New Haven, CT: Yale University Press.

Martinez, P., and J.E. Richters. 1993. The NIMH community violence project II: Children's distress symptoms associated with violence. *Psychiatry* 56:22–35.

New Haven Public Schools. 1992. Report on the SAHA. *Social Development Project Evaluation, 1991–92: Final Report.* 179–196.

Palmer, T. 1983. The 'effectiveness' issues today: An overview. *Federal Probation* 47:3–10.

Richters, J.E., and P. Martinez. 1993. The NIMH community violence project I: Children as victims of and witnesses of violence. *Psychiatry* 56:7–21.

Schorr, Lisbeth B. 1989. *Within Our Reach.* New York, NY: Doubleday & Co., Inc.

Sheley, J.F., and J.D. Wright. 1993 (December). *Gun Acquisition and Possession in Selected Juvenile Samples.* Washington, DC: National Institute of Justice and Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice.

Singer, M., T. Anglin, L. Song, and L. Lunghofer. 1995. Adolescents' exposure to violence and associated symptoms of psychological trauma. *Journal of the American Medical Association* 273(6): 477–482.

Taylor, L., B. Suckerman, V. Harik, and B. McAlister-Groves. 1992. Exposure to violence among inner-city parents and young children. *AJDC* 146:487–494.

Thornberry, T. 1994. Violent Families and Youth Violence. Program of Research on Causes and Correlates of Delinquency. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice.

Vitulano, L.A., et al. 1996. Children and Violence: Posttraumatic Stress Disorder with Conduct Disorder. (Invited address at the American Psychological Association in Toronto, ON, August 10, 1996.)

Wiese, D., and D. Dara. 1995. *Current Trends in Child Abuse Reporting Fatalities: The Results of the 1994 Annual Fifty State Survey.* Chicago, IL: National Committee to Prevent Child Abuse.

This Bulletin was written by project staff of the Child Study Center, Yale University School of Medicine. Steven Marans, M.S.W., Ph.D., is Harris Assistant Professor of Child Psychoanalysis, and Miriam Berkman, J.D., M.S.W., is an assistant clinical professor in social work.

It was prepared under grant number 95–JN–FX–0022 from the Office of Juvenile Justice and Delinquency Prevention (OJJDP), U.S. Department of Justice.

Points of view or opinions expressed in this document are those of the authors and do not necessarily represent the official position or policies of OJJDP or the U.S. Department of Justice.

The Office of Juvenile Justice and Delinquency Prevention is a component of the Office of Justice Programs, which also includes the Bureau of Justice Assistance, the Bureau of Justice Statistics, the National Institute of Justice, and the Office for Victims of Crime.

U.S. Department of Justice
Office of Justice Programs
Office of Juvenile Justice and Delinquency Prevention

Washington, D.C. 20531

Official Business
Penalty for Private Use $300

BULK RATE
POSTAGE & FEES PAID
DOJ/OJJDP
Permit No. G–91

BEST COPY AVAILABLE

NCJ 164380

THE CHILD PSYCHIATRIST IN THE COMMUNITY 1056-4993/98 $8.00 + .00

POLICE AND MENTAL HEALTH PROFESSIONALS

Collaborative Responses to the Impact of Violence on Children and Families

Steven Marans, PhD, Steven J. Berkowitz, MD, and Donald J. Cohen, MD

The Child Development–Community Policing project, developed in New Haven, Connecticut, is a collaboration of the Yale University Child Study Center and the New Haven Department of Police Service. Its primary goal is to assist children and adolescents who have been exposed to or victimized by violence. Too often, in the past, police officers would arrive at a violent scene and believe they had no other choice other than to ignore or avoid the children present. The Child Development–Community Policing project is an attempt to intervene quickly and effectively with those children who are the psychological victims of violence and often its perpetrators as well.

A replication of the program is now being implemented and explored in communities throughout the country as an important approach to the support of victims and to the prevention of crime. At present, seven cities are implementing the program and reporting positive and exciting results in the beginning of their collaborative efforts. On April 17, 1997, President and Mrs. Clinton hosted a White House Conference on Early Childhood Development and Learning; in his opening remarks President Clinton lauded the New Haven Child Development–Community Policing project. He announced:[42]

> The Department of Justice is establishing a new initiative called "Safe Start," based on the efforts in New Haven, Connecticut . . .

From the Yale Child Study Center, Yale University School of Medicine, New Haven, Connecticut

> The program will train police officers, prosecutors, probation and parole officers in child development so that they'll actually be equipped to handle situations involving young children. And I believe if we can put this initiative into effect all across America, it will make our children safer.

Large numbers of children in this country are exposed to violence in their homes, at school, and in their neighborhoods. The potential numbers of psychological casualties far outnumber the physically wounded seen in emergency rooms. For example, at Boston City Hospital, one out of every 10 children seen in the primary care clinic reported witnessing a shooting or stabbing before 6 years of age, half in the home, half on the streets. The average age of these children is 2.7 years.[24] In New Haven, 41% of sixth-, eighth-, and tenth-grade students reported seeing someone shot or stabbed in the preceding year.[15] Among boys in some high schools as many as 21% reported seeing someone sexually assaulted; 82% witnessed a beating or mugging in school; 46% had seen someone attacked or stabbed with a knife; and 62% had witnessed a shooting.[22]

Exposure to interpersonal violence disrupts the basic preconditions for optimal child development. In the face of stabbings, beatings, and shootings, the child may be traumatized as he or she is unable to contain the stimulation within existing mental and neurophysiologic structures that enable accommodation and assimilation. When systems are immobilized, a cascade of psychological and neurophysiologic processes ensues. Children may develop specific, circumscribed symptoms, such as disruptions in sleeping, eating, and toileting. In addition, they may become generally fearful with an accompanying dysregulation of arousal systems; they jump with street noises and flashback images of the violent event invade their minds.[1, 9, 11, 20, 21, 25] In turn, they may become distracted, unable to concentrate or pay attention in school or at home. Transient oppositional behavior at home or at school may be both an attempt for the child to reassert power in the face of feeling vulnerable and an effort to cope with the anxiety and hyperarousal caused by the dysregulation of the noraderanergic system. When the child is exposed to the dangers of violence on a chronic basis, however, symptoms may no longer serve the function of restitution and recovery. Rather, the child's symptoms become chronic and maladaptive such that physiologic, cognitive, and emotional capacities are severely impaired. Chronic violence punctuated by acute episodes is associated with increased depression and anxiety, alcohol use, and lower school achievement.[6, 14, 21, 25]

Most tragically for the child and society, another long-term adaptation to ongoing violence is the perpetration of violence. In densely populated, impoverished urban areas where the prevalence of violence is especially high there may be a natural progression from witnessing to being the victim of and then to engaging in violence.[10] The children who shoot and stab other children have all too often been exposed to the abusive relationships of family members, and have themselves been at

the receiving end of beatings and neglect. Frightened victims become frightening assailants. In a study of children in Rochester, New York, children who had been victims of violence within their families were 24% more likely to report violent behavior as adolescents than those who had not been maltreated in childhood. Adolescents who were not themselves victimized but who had grown up in families in which partner violence occurred were 21% more likely to report violent delinquency than those not so exposed. Overall, children exposed to multiple forms of family violence reported twice the rate of youth violence as those from nonviolent families.[26] In a survey of New York City's juvenile detention facilities, 79% of juveniles had seen someone stabbed or shot; 58% had a family member who had been shot or stabbed; and 38% had been shot or stabbed themselves.[4] For several years, we have been witnessing the same increasing trend in both child abuse and juvenile arrests.[5, 12] For instance, in 1994, 2829 children and adolescents were arrested for criminal homicide and 5369 were arrested for rape.[29] Overall, juvenile arrests for violent crime rose approximately 47% between 1988 and 1992; juvenile arrests for weapons offenses rose 66%.[28] The 1996 juvenile crime statistics demonstrated a dramatic decrease: from 1980 through 1994 an estimated 326, 170 persons were murdered in the United States, and of these murder victims 9% or 30,200 were less than 18 years of age; there was a 1% increase from 1980 through 1994 in the total number of murders; in 1980 juveniles were murdered at a rate of five per day, whereas in 1994 the rate was seven per day; the majority of juveniles killed (53%) in 1994 were between 15 and 17 years of age and 30% were less than 6 years of age; and in 1994, one in five murdered juveniles was known to be killed by a juvenile offender.[17]

As more is learned about the complex interaction and reinforcement of psychological and neurobiologic responses to overwhelming events, there is good reason for concern about the enduring consequences for children's maturation and development when trauma responses go unrecognized and untreated. Studies of the neurobiology of posttraumatic stress disorder (PTSD) in adults demonstrate a fundamental alteration in the catecholamine neurotransmitter systems.[23] This observation has been confirmed in children by Perry[18] who has observed autonomic dysregulation in children with severe and chronic PTSD. In a small pilot study of children with PTSD (eight patients), Perry measured platelet α-2 adrenergic binding sites; when compared with controls, the PTSD group had fewer total binding sites.[18] This finding in children, similar to findings in adults, demonstrating a downregulation of peripheral adrenergic receptors implies a higher level of circulating catecholamines related to increased activity of the sympathetic nervous system.[19] Cardiovascular abnormalities also were demonstrated in 34 children with PTSD, including high resting heart rates and greater heart rate lability in response to orthostatic challenges.[18]

Additional central nervous system (CNS) changes have been correlated with PTSD. Some of these changes include the neuroanatomic finding that the right hippocampus in adults with PTSD is smaller as

compared with matched controls,[2] which may have important implications regarding a child's memory and ability to learn and retain new information. Additionally, dysregulation of the hypothalamic-pituitary axis appears to be another hallmark of PTSD confirmed by low basal cortisol levels of adults with PTSD as compared with controls.[30, 31] These neurobiologic findings in adults, now being replicated in children, are even more significant when one considers the impact that chronic environmental trauma may have on the developing brain. For instance, Vietnam veterans with PTSD are more likely to have experienced childhood abuse[3] than combat veterans without PTSD. In general, it appears that chronic exposure to violence may prime the CNS to be more vulnerable to a myriad of psychiatric symptoms and disorders.[3, 8, 18, 27]

In light of the existing rates of violence in our society and our growing knowledge about the neurobiology of chronic enduring stress and PTSD and their developmental sequelae, one recognizes that exposure to violence and psychological trauma may be one of the most important public health issues faced today. Primary prevention programs alone are unlikely to stop the spread of these symptoms and children will continue to be exposed to violence and suffer from its effects. Early intervention immediately after a serious traumatic event is both possible and desirable, however. Psychological and pharmacologic interventions may be able to prevent the acute stress response from becoming permanently dysregulated. It is hoped that by intervening immediately after the event, the integration of the experience for the child and family may prevent the perpetuation of fear and stress that may exacerbate and concretize the acute biologic and maladaptive coping responses. The New Haven Child Development–Community Policing Program offers just such a response.

COLLABORATIVE INTERVENTIONS: THE NEW HAVEN/ YALE CHILD STUDY CENTER MODEL

Responding to shared concerns, the Yale Child Study Center and the New Haven Department of Police Service developed a unique and innovative program that alters the ways in which both policing and mental health services are delivered to children and families who are regularly exposed to community violence.[9, 11, 13] Although police officers come in daily contact with children who are victims, witnesses, and perpetrators of violence, they generally do not have the professional expertise, the time, or the other resources necessary to meet these children's psychological needs. Conversely, clinic-based mental health professionals may be professionally equipped to respond to children's psychological distress following episodes of violence, but these acutely traumatized children rarely are seen in existing outpatient clinics until months or years later, when chronic symptoms or maladaptive behavior bring them to the attention of parents, teachers, or the juvenile courts. When there are no collaborative responses immediately following violent

incidents, valuable opportunities to intervene may be lost at precisely the moment when concerted police and mental health contact could provide both immediate stabilization and bridges to a variety of ongoing services to address the trauma and maladaptive symptomatology.

The New Haven Child Development–Community Policing Program places mental health professionals in the community, with the police, to develop collaborative strategies for preventing violence and intervening early when it occurs. The program involves five central components:

1. A core seminar for rank-and-file officers on the application of principles of development and human functioning
2. A fellowship that exposes police supervisors to clinical services and liaison with social services
3. A fellowship for clinicians that orients them to police practices
4. A 24 hour per day consultation service for officers, children, and families who are directly involved in violent incidents, in which an officer can contact a clinician by beeper at any time
5. An ongoing case conference for officers and clinicians who discuss clinical and policing interventions for victims and perpetrators of violence[9, 13]

The program relies on a process of learning about the perspectives and experience of the other professional as a basis for considering the developmental implications of their respective observations and actions. Clinicians have learned that to be useful to police officers they first must see the clinical phenomena from the officer's point of view. This has been accomplished through the development of fellowships for clinicians and supervisory officers. In the Police Fellowship, clinicians move into police settings—whether through ride-alongs in squad cars, joining police at crime scenes, or sitting in on discussions of case investigations—and learn about their tasks, demands, and professional needs. At the same time, through the Clinical Fellowship, officers become familiar with mental health settings and psychodynamic and developmental perspectives through observations of clinical activities and consultations. Also, a 24-hour consultation service and weekly case conference provide ongoing opportunities for applying developmental concepts in the field. Whereas each of these components serves as a basis for the continued development of the partnership, the seminars developed by senior police officers, the Yale Child Study Center analysts, and analytically informed clinicians provide the shared conceptual framework that guides observations, discussions, and interventions.

SEMINARS ON CHILD DEVELOPMENT, HUMAN FUNCTIONING, AND POLICING

The central task of the seminars is to engage officers in the examination of concepts regarding the following: basic human needs; developing capacities for self-regulation and mastery; phase-specific sources of dan-

BEST COPY AVAILABLE

ger and anxiety; the link between behavior and underlying psychic processes (i.e., the relationship between anxiety and defenses); and individual variation with regard to potential life adaptations. Proceeding along a developmental sequence, the seminars also highlight the ways in which phenomena originating in an earlier phase of development may be observed in various forms throughout the life cycle. Seminar leaders use scenarios encountered in police work, films and videotapes about children, and cases initiated through the consultation service to demonstrate that a greater understanding of human functioning does not mean inaction or decreased vigilance with regard to personal safety. Rather, the goal of the seminars is to help officers discover new ways of observing and formulating responses to children that are informed by an understanding of their development. In addition, officers have the opportunity to establish a more realistic appreciation of the impact they can have on the lives of children and families with whom they interact.

Following a first meeting in which seminar members introduce themselves and talk about their expectations of the course, discussions begin about early development. The topic of infancy is introduced by the supervisory officer, who co-leads the seminar with a clinician who describes the following scene: "You have responded to a complaint of breach of the peace and arrive at an apartment where music is blaring. You are greeted by an angry young mother, an apartment that is disordered and dirty, and three children in similar disarray, less than 4 years of age. Diaper changes for two of the children appear long overdue. What is your reaction?" The officers often begin the discussion by expressing their feelings of despair and anger about a scene that is all too familiar. As the instructors probe the nature of these reactions, the class begins to identify concerns about the babies who are unable to fend for themselves, about the children's physical discomfort, and about the notion that the mother doesn't care enough about them. What emerges from the discussion is the group's awareness of an infant's physical and emotional needs and the role of the mother in mediating and responding to them. The seminar leaders ask, "And what happens to the infant if those basic needs aren't met?" The answers run to the idea that the baby will be overwhelmed with pain, discomfort, and despair because the baby is not yet equipped to feed, clothe, comfort itself, or satisfy the demands of its feelings on its own. The leaders ask for more details and the class responds by identifying the child's capacities—the absence of verbal language, motoric maturation and coordination, cognitive processes for problem solving, and finally, the utter reliance of the infant on the mother for the experience of physical and emotional well-being. Attention is then focused on the young mother. How, the leaders ask, do we understand her apparent insensitivity or incompetence? The discussion must first address her surly response to the officers and their indignation. At this point two important concepts are introduced. As seminar leaders introduce clinical phenomena that underlie presenting behavior participants begin to discuss symptoms that they quickly recognize but have not necessarily associ-

ated with depression and stress. Invariably the discussion turns to examples of irritability and heavy alcohol use. This becomes an excellent opportunity to discuss the complex biologic and psychological relationship between stress, anxiety, depression, and substance abuse. In addition, the concept of transference is introduced. The seminar leaders expand the discussion of a young woman apparently unable to look after her children, let alone herself. They ask, "How might she feel about herself?" The answers vary. "Like a failure?" "Maybe she just doesn't care!" The seminar leaders ask, "Given either of those possibilities, how might she feel when two police officers come to her door?" The response usually is "Like we're going to tell her off, tell her what she should be doing, how she should behave." "And who are you to her at that moment? Who tells *you* you're not getting it right, messing up? Parents? teachers? a critical boss or colleague?" In one session, an officer jumped in and offered, "Right, and then when she feels criticized, she takes on an obnoxious attitude and treats us like dirt." Another officer added, "As though she already knows who you are." In this particular discussion, the clinical co-leader suggested that perhaps from the moment of their arrival, the officers represent something very familiar to the young woman. The clinician added, "Before you open your mouth, you may be the critical voice, the presentation of authority, the voice that agrees with her own self-criticism and assessment of incompetence. How does it feel to be criticized? What is it like to feel inadequate and to have someone, by their very presence on your doorstep, point it out to you? Is it possible that her surly and combative response serves a defensive function that is triggered by you but not about you personally?" And the discussion goes on, often ending with some greater appreciation for the complexity of the scene and the interaction but with the residual wish to do something concrete for the babies. This latter wish is to either implore the woman to be a more attentive mother, or to remove the children so that they can have a better home.

The Robertson's film *John*[21a] is shown in the following session. In the discussion that follows, seminar members describe the 17-month-old child's efforts to soothe himself in the midst of a 9-day separation from his parents. They note John's attempts to reach out to the child-care nurses, cuddly toys, and the observer, and his utter despair when these efforts fail. The discussion also compares John with the other children who have spent their entire lives in the residential nursery. Seminar members often observe that while seeming unfazed by the limited attention and multiple changes of nursing staff, in contrast to John, these children appear dominated by aggressive, driven, and need-satisfying behavior. In attempt to understand why John may be so vulnerable to the disruption in care, the seminar begins to consider individual differences and the transaction among genetics, temperament, and environment. Who John is as a synthesis of his biology and psychology is a central topic for conversation. Slowly and often painfully, as the discussion continues, the simple solution of removal from care when parenting seems inadequate fades. The idea that removal always represents rescue

BEST COPY AVAILABLE

is replaced by a growing appreciation for the complexity of the child-parent relationship. This includes a recognition of the developmental significance of continuity of care and the impact of disrupting it. In addition, seminar members have a fuller understanding of the balance between the child's needs and capacities as well as the distress that follows when needs aren't met.

The link between these processes and overt behavior and the observers' responses and overt behavior is pursued as the seminar moves into the next session in which the hallmarks of the toddler phase are introduced. Using videotapes of normal children engaged in imaginative play, officers are able to consider the child's use of fantasy, identifications, and burgeoning cognitive and physical resources to achieve inhibited sources of pleasure and mastery. Failures in negotiating oedipal conflicts over competition, envy, love, and hate and the often unstable, overstimulating home situations are explored in discussions of latency-age children who come to the attention of police because of their antisocial activities. Similarly, puberty is discussed in terms of the intensification of struggles over sexual and aggressive urges.

Seminar leaders introduce phases of development by asking officers to describe the most salient aspects—either observed or assumed to play a part—of a given period of life. As the discussion evolves, officers often invoke their own memories as a vehicle for understanding the behaviors they observe and encounter on the street and as a way of becoming conscious of the complicated identifications that these interactions may evoke. For example, when discussing puberty and early adolescence officers initially describe their concerns about provocative, tough, drug-involved, or pregnant kids and the frustration they experience when logic and warnings about consequences seem to have no impact on behavior. As they begin to talk about their own experiences of this phase of development, however, the frustration and angry dismissal of these kids is substantially altered. Officers often describe memories from their own lives or about particular children whom they have met over the course of their work and have not been able to forget. All of the accounts speak to the vulnerability, anxiety, and loneliness so common in this period of development and the various means used to defend against these feelings. Stories of fighting, social isolation, school difficulties, and losses alternate with the ones about best friends, first girl- and boyfriends, team sports, and the like. The discussions inevitably focus on concern about body image, group acceptance, struggles with parents, losses, and the overarching experience of embarrassment and urgency in the competing wishes for competent, independent functioning and utter incompetence and the embarrassing wish to remain a small child.

John Singleton's film, *Boyz n' the Hood* is used as the text for the seminars that deal with adolescence. Many who have seen or heard about it assume that it is simply an action-packed film depicting gang warfare in central Los Angeles. As the seminar participants come to the end of the course, however, they are surprised to discover that regardless of the setting, the story is about development in an especially familiar

territory: the challenges, hopes, and dilemmas inherent in adolescence. The discussion moves from issues of race and inner-city socioeconomics to a focus on the internal and external contributions to the fate of two brothers in the film—one becomes a gun-toting drug dealer and the other a high-school football star bound for college until he is shot dead by gang members.

As the seminars come to an end, officers increasingly refer to their responses to the scenes of violence and suffering they confront on a daily basis. Sealing over, "getting used to it" and distancing themselves as best they can, displacing their frustration onto citizens with whom they interact or family members, viewing the world dichotomously (i.e., "us versus them"), and heightening the sense of vigilance are all common themes that emerge in the discussions. These responses are discussed in terms of the defensive functions they serve against unwanted feelings of fear, inadequacy, sadness, despair, and anger, as well as the potential interference they may pose in achieving the desired goals of their interventions.

CHANGES IN POLICE RESPONSES

Regardless of the setting, the aim of the discussions for both officers and clinicians is to "place ourselves in the position of children of different ages, of different developmental phases, and of different backgrounds."[7] For the officers, the opportunity to reflect on what they observe, to have a framework for ordering what might have otherwise been too overwhelming to notice, and to have colleagues with whom to share the burden of responding—at any hour—has led to dramatic changes in police practices regarding children. These changes are reflected in officers regularly referring children who have witnessed and experienced violence, and, increasingly, children who have committed serious violent offenses.

Similarly, officers have become more attentive to the humiliation and greater potential for dangerous confrontation when they deal with adolescents, especially juvenile offenders, in a harsh manner. As officers have become regular fixtures in the neighborhoods, they have replaced anonymous responses to the groups of kids on the streets with interactions that are informed by familiarity and individual relationships. From the seminars to the streets, this contact is enhanced by officers' increased appreciation of normative adolescent upheaval that is so often compounded by the despair and impotence associated with severe social adversity. As a result, wholesale condemnation, frustration, and anger are not the only responses to the provocative or illegal behavior with which adolescents confront them on a daily basis. The recognition of the transference and countertransference phenomena that are so often associated with police-adolescent interactions on the street also has led to a more judicious and strategic use of authority. In turn, police imposition of authority (e.g., clearing a street corner known for drug activity,

BEST COPY AVAILABLE

keeping public noise down, picking up truant students, and so forth) is more frequently met with compliance rather than an immediate escalation to violent confrontation and arrest.

Over the past several years, hundreds of line officers and dozens of senior supervisory police have been trained in the principles of child development and acute traumatic responses. The police have welcomed participation in the program and have believed that it has enhanced their professional functioning as police officers. Collaboration with other professionals also has helped them deal with the alienation and burnout of their ceaseless confrontation with senseless pain and injury. Working alongside mental health professionals, police officers have been able to respond more humanely and effectively to more than 1000 children in New Haven who have witnessed and experienced violence, as well as hundreds of children who have committed violent crimes. Many of these children and adolescents have received psychological intervention within minutes of being exposed to murders, stabbings, beatings, and maiming by fire, drownings, and gunfire. In an effort to address all concerns, the clinical team is composed of psychiatrists, psychologists, and social workers. All manner of clinical assessment and intervention is available both immediately after the event and whenever it is needed during the course of treatment. Together with pediatricians, primary care providers, and other non–mental health colleagues, the clinical team addresses neurophysiologic processes and psychiatric, psychosocial, and environmental concerns, and then attempts to develop the most effective and useful range and type of interventions. Children have been cared for employing many different modalities and have been treated individually and as part of larger groups in their homes, at police substations, at school, in their neighborhoods, and within the Yale Child Study Center. A major result of the police–mental health collaboration has been the expansion of the clinical field of observation. Therapeutic contact is now initiated on the scene by officers and mental health professionals. Whereas the application of developmental principles has affected police approaches to typical interactions with youth on the streets and in the schools, it also has led to interventions that are anything but standard in the traditional approach to law enforcement. Following the shooting death of a 17-year-old gang member, there was good reason for concern about retaliation and further bloodshed. In the days that followed the death, grieving gang members congregated on the corner where the shooting had taken place. The efforts at increased presence and removal and containment of violence was in the form of police, neighborhood-based probation officers, and clinicians spending time on the corner listening to gang members express their grief. As one senior police officer put it, "We could show our concern for their trauma by being with them, lending an adult ear to their misery. Alternatively, we could put more officers on the street, show them who's boss and, with a show of force, sweep them off the corner as often as necessary. . . . We could then offer them an additional enemy and wait for them to explode." At the crucial moment, however, the police did not assume the role of

BEST COPY AVAILABLE

enemy. They did not serve as the target for displaced rage or, in confrontation, offer an easy antidote to sadness and helplessness. Rather than exacting payback in blood, the common gang pathway for turning grief into action, the gang discretely assisted the police in making a swift arrest in the shooting. As the brother of the victim put it to a neighborhood cop, "You were there for us, that helped . . . and we were there for you."

RESPONSES TO TRAUMA

Whereas officers now have an opportunity to expand their knowledge and repertoire of interventions, the collaboration with the police has allowed child therapists a new setting in which to increase their understanding of the impact of violence and trauma. Discussions about referrals from the consultation service frequently focus on the extent to which children describe the violent events they have witnessed in terms of the developmental phase-specific anxieties that are aroused. By following the unfolding stories of the children exposed to violence, child therapists are able to see more clearly what constitutes the specific dangers that overwhelm the individual child, or what aspects and meanings of the event are experienced as exceptional, overwhelming, and therefore traumatizing. All too often, clinical assumptions and notions about the nature of a child's traumatization seem to be determined by the facts about the violence witnessed. These assumptions may have very little to do with the child's experience of the event or the meaning that is attributed by the child in its aftermath. In turn, there may be little attention paid to learning about the child to begin to appreciate what an experience of violence might be for the individual child in the context of his or her life history, temperament, family constellation, phase development, or defense configuration, and therefore, what interventions might be most useful. For clinicians and officers alike, closer attention to the details of the individual child's experience has prompted changes in their response.

Case Study

Sargeant G described an incident in which a 7-year-old girl witnessed a beloved neighbor bleed to death after being fatally stabbed by another neighbor. Believing he was protecting her from the gore of the crime scene, Sargeant G had the child wait on the porch outside while officers conducted their investigation. He was haunted by the intent gaze, a mixture of despair and rage, that the girl fixed on him when he finally invited her back into the apartment as the officers were leaving. The next day the sargeant went back to the house and spoke with the girl and her grandmother and understood that his attempt at being helpful had been without the benefit of considering what this girl was experiencing, what was needed, and from whom. As he explained in the case conference, "Especially in the midst of so much blood and terror, what she needed was to be close to her grandmother, the most stable figure in her life,

BEST COPY AVAILABLE

not to be stranded alone with images of the scene." Both the girl and her grandmother eagerly accepted his offer of a referral for clinical services. As it emerged in her treatment, being alone with frightening themes and fantasies involving extremes in love and hate was common for this young girl. Her heroin-addicted mother appeared in and out of her life, and she was additionally burdened by her realistic uncertainty about her grandmother's health and longevity. Both internalized and external conflicts were boldly underlined by her confusion of loyalties in the stabbing. Although she mourned the death of one beloved and idealized maternal substitute, she anxiously told her therapist about the love letters she was writing to the assailant, now in jail on murder charges, but somehow viewed as safer and more available than her inconsistent and absent mother.

Case Study

The therapist's focus on helping the patient to integrate the child's detailed description of violent events with phase-appropriate concerns and past conflicts is illustrated again in this second case. Mark, 15 years of age, was robbed at gunpoint on a Friday evening. He'd been walking with friends when two men put a reportedly large-caliber semiautomatic weapon in his face and demanded all of his money and gold jewelry. Mark had been walking behind several friends and they were unaware of what was now occurring in an alleyway off of the main sidewalk. Mark later reported that men repeatedly shoved the weapon in his face and told him they would shoot him. After taking his valuables the assailants fled and Mark ran home. He ran into his room crying uncontrollably, hid on the floor of his closet, and, in spite of his mother's urging, refused to come out. After a while, through sobs Mark told his mother what had occurred and she phoned the police. Each of the three officers that arrived had been trained in the child development seminars; the supervisory officer had completed the fellowship. As one of the officers approached the bedroom, Mark began to scream. The officer told him that he had heard what had happened to him and realized the hold-up was a terrifying experience. Mark would not look at the officer and yelled at him to leave the room. The officer was about to leave when the supervisor pointed to his gun and utility belt. With this the officer removed his holster and weapon, explaining to Mark that he would leave them outside of the room because he understood how frightening guns might be to him. Mark continued to sob and shake uncontrollably but allowed the officer to help him out of the room and accepted the suggestion that he go to the emergency room for treatment. The consultation service clinician was called and met Mark at the hospital.

During the course of the interview, Mark was only able to look at the clinician after a comment was made about how feeling very frightened could make a guy feel small and helpless, a very undesirable feeling for a 15-year-old boy. Mark began to talk about the events, repeating the same scene and assailants' commands to him over and over. The repetition began to include some slight alterations in the facts, and Mark protested that he should have "grabbed the gun and kicked each of the [attackers] in the balls." He described the size of the gun muzzle as huge and insisted that he thought they would kill him with this huge weapon. As his shaking, hyperventilation, and sobbing subsided, Mark began to talk about the earlier part of the evening. He explained that before being robbed he had been "hanging back from his homeboys because they were with their ladies" and he wanted to "give them space." He shyly told

BEST COPY AVAILABLE

the clinician that he didn't have a girlfriend and then quickly exploded with rage and then tears. He wanted to get a gun and kill the guys who "messed with him." He didn't deserve what had happened to him—he was a good student in school and had just completed an important history paper. He explained that he'd bought all of the thin gold chains he wore for himself, clarifying that he was not to be lumped together with "low-life drug dealers." Mark began to cry again, as he swore revenge. The clinician commented that it felt humiliating to have to feel so terrified and that Mark was wishing that he could undo his experience. Mark replied that if he had a gun or had disarmed his attackers, he wouldn't have to feel as though he'd "wimped out." The clinician agreed that feeling powerful would certainly be the opposite of what he had experienced with a gun in his face. Mark brightened and looked up suddenly, exclaiming that now he remembered the gun more clearly—it wasn't a 9-mm semiautomatic, it was a BB gun. As the acute terror diminished, he was also able to remember the make of the car they took off in as well as clear descriptions of the two men. His restitution fantasies of revenge began to take another form as Mark talked about helping the police make an arrest. On his request, Mark spoke with the detective involved in the case to offer the information he had recovered in the course of the interview. Two hours after the admission to the emergency room, Mark was discharged.

Mark was seen in outpatient sessions in which he continued to go over the events of that Friday evening as well as exploring equally disturbing lifetime events. The fantasies of what he should have done in both domains were intermingled with talk of the mortification of feeling helpless and the increasing recognition that, in fact, there was nothing that he could have done to alter what had occurred. In addition to his hard work in psychotherapy and his enrollment in a special academic program, another ingredient has played a crucial role in Mark's improved adaptation. In the months that followed the robbery, the officer who had unhitched his utility belt began stopping in on him regularly for brief chats during the course of his usual beat patrol. The officer's friendship and authoritative monitoring played an essential role in deterring Mark from what emerged as his beginning involvement with drug dealing and engaging him in an afterschool activities group. Eighteen months after the incident, Mark has still not "scored" a gun, and instead of continuing to recite numerous violent revenge fantasies, he recently spoke of the latest academic demands at school and of his friendships with the cops on his beat. Although he has not forgotten the terror or rage associated with his experience, Mark knew that his good memory had been instrumental in the arrest and later conviction of the two men who had attacked him. And, as he said, "That feels really good."

EXTENDING THE MODEL

In recent years the police mental health collaboration has been extended to include other child service providers. Now, as part of the program, police, juvenile probation officers, social service workers, and mental health professionals in New Haven are working together to address the inefficiency and ineffectiveness of the juvenile justice system in addressing the needs of children and adolescents involved in violent and other criminal activities. Many children arrested for delinquent acts have been known to multiple professionals prior to their involvement

in the juvenile justice system. Arrest therefore can represent an opportunity for collaboration and interdisciplinary problem solving as an alternative to traditional approaches that emphasize the independence of the court and associated agencies, which often result in duplication of efforts or court-ordered stipulations that are mismatched to the child's needs. In the current collaboration police and probation officers have begun to share supervision and monitoring of juvenile offenders by relocating probation officers to community substations and by engaging neighborhood officers in supervising community service projects for youth on probation. Comprehensive clinical evaluations are combined with information contributed by probation, police, child welfare, mental health and educational services so that intervention can be developed, coordinated, and monitored from multiple dimensions of the child's life. These services include the integration of individual and group psychotherapies, mandated community service, curfews, shared probation, police monitoring, and supervision, special education, and family services, some or all of which constitute the treatment package.

No single group of professionals is able to address the multiple needs of the children and families subject to massive environmental stress. When professionals attempt to intervene in isolation of one another, the multiple and awesome needs of these profoundly stressed children and families become overwhelming. The collaboration among police, probation officers, social service workers, and mental health professionals in New Haven provides a model of interdisciplinary action on behalf of children at great developmental risk owing to their exposure to violence who would be unlikely to receive effective intervention through traditional models of social service delivery.

SUMMARY

Coordinating responses through the Child Development–Community Policing Program has led to multiple changes in the delivery of clinical and police services. Mental health clinicians and police officers have developed a common language for assessing and responding to the needs of children and families who have been exposed to or involved in violence. Learning from each other, these unlikely partners have established close working relationships that improve and expand the range of interventions they are able to provide while preserving the areas of expertise and responsibilities of each professional group. The immediate access to witnesses, victims, and perpetrators of violent crimes through the consultation service provides a unique opportunity to expand the understanding of clinical phenomena from the acute traumatic moment to longer-term adaptation, symptom formation, and recovery. In turn, the initiative introduces the systematic study of basic psychological and neurobiologic functions involved in traumatization as well as the investigation of psychotherapeutic and pharmacologic therapies. Similarly, program involvement with juvenile offenders has

led to a coordinated response from the police, mental health, and juvenile justice systems. This project provides an opportunity to develop detailed psychological profiles and typologies of children engaged in different levels of antisocial behavior as well as to determine the characteristics that might predict with whom community-based interventions might be most successful. A recent survey of New Haven public school students has yielded promising evidence that community policing and the program are having a positive impact on the quality of life. In a survey of sixth-, eighth-, and tenth-grade students there were substantial improvements in students' sense of safety and experience of violence between 1992 and 1996. When asked if they felt safe in their neighborhood, there was an increase in the percentage of positive responses from 57% to 62% for sixth-grade students, 48% to 66% for eighth-grade students, and 53% to 73% for tenth-grade students, and when asked if they had seen someone shot or stabbed there was a decrease in positive responses from 43% to 28% for sixth-grade students, 46% to 31% for eighth-grade students, and 34% to 28% for tenth-grade students.[16]

Today, we are all too familiar with the developmental trajectory that leads children into violent crime. Newspaper articles and clinical case reports have taken on a dreary repetitiveness. These young criminals are often poor, minority, inner-city children who are known to many agencies to be at risk because of family disorganization, neglect, and abuse. They are failing in school or are already on the streets. One day they are victims and the very next they are assailants. We are all familiar with the inadequacies in the social response to these children, from their preschool years through the point at which they become assailants themselves. What is shocking is that the age at which children make the transition from being abused to being abusive seems to be getting earlier, and the number appears to be increasing. On the positive side, there is an increased awareness of the need and the ability of the various sectors of society to respond in concert. The institutions that function in the inner city—schools, police, mental health and child welfare agencies, churches—are all concerned about the same children and families. By working together, with a shared orientation to the best interests of the children, they can intervene earlier and more effectively: first, to disrupt the trajectory leading to violence; and, second, to help those children who are already caught in the web of exposure to violent crime and inner-city trauma. The experience with community-based policing and mental health in New Haven, now being replicated throughout the United States, can thus stand as a model of an active social response to an overwhelming national concern.

References

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, ed 4. Washington, DC, American Psychiatric Association, 1994
2. Bremner JD, Randall P, Scott TM, et al: MRI-based measurement of hippocampal

BEST COPY AVAILABLE

volume in patients with combat related posttraumatic stress disorder. Am J Psychiatry 152:973–981, 1995
3. Bremner JD, Southwick SM, Johnson DR, et al: Childhood abuse in combat-related post traumatic stress disorder. Am J Psychiatry 150:235–239, 1993
4. Citizens' Committee for Children: Keeping Track of New York's Children. New York, NY, Citizen's Committee for Children, 1993
4a. Clinton WJ: What new research on the brain tells us about our youngest children. Presented at the White House Conference on Early Childhood Development and Learning, April 17, 1997
5. Commission on Children: Beyond Rhetoric: A New Agenda for Children and Families. Washington, DC, Library of Congress, 1992
6. Garbarino J, Dubrow N, Kostelny K, et al: Children in Danger: Coping with the Consequences of Community Violence. San Francisco, Jossey-Bass Publishers, 1992
7. Goldstein J, Freud A, Solnit AJ: Beyond the Best Interests of the Child. New York, Free Press, 1979
8. MacFarlane AC: Vulnerability to posttraumatic stress disorder. *In* Wolf ME, Mosnaim AD (eds): Posttraumatic Stress Disorder: Etiology, Phenomenology and Treatment. Washington, DC, APA Press, 1990
9. Marans S: Community violence and children's development: Collaborative interventions. *In* Chiland C, Young G (eds): Children and Violence. Northvale, NJ, Jason Aronson, 1994, pp 109–124
10. Marans S: Psychoanalysis on the Beat: Children, Police and Urban Trauma. *In* Solnit A, Neubauer P, Abrams S, et al (eds): Psychoanal Study Child 51:522–541, 1996
11. Marans S, Adelman A: Experiencing Violence in a Developmental Context. Osofsky J (ed): Children in a Violent Society. NY, Guilford Press, 1997, pp 202–222
12. Marans S, Berkman M, Cohen D: Communal Violence: Children's Development and Their Adaptations to Catastrophic Circumstances. *In* Apfel R, Simon B (eds): Minefields in Their Hearts: The Mental Health of Children in War and Communal Violence. New Haven, Yale University Press, 1996
13. Marans S, Cohen DJ: Children and inner-city violence: Strategies for intervention. *In* Leavitt L, Fox N (eds): Psychological Effects of War and Violence on Children. Hillsdale, NJ, Lawrence Erlbaum, 1993, pp 218–301
14. Martinez P, Richters J: The NIMH Community Violence Project: II. Children's Distress Symptoms Associated with Violence Exposure. Psychiatry 56:22–35, 1993
15. New Haven Public Schools: Report on the SAHA. Social Development Project Evaluation, Final Report 179-196. New Haven, New Haven Public Schools, 1992
16. New Haven Public Schools: Report on the SAHA. Social Development Project Evaluation, Final Report. New Haven, New Haven Public Schools, 1997
17. Office of Juvenile Justice and Delinquency Prevention Internet Site. *http://www.ojp.usdoj.gov.80/bjs*, 1996
18. Perry BD: Neurobiological Sequelae of Childhood Trauma: PTSD in children. *In* Murburg M (ed): Catecholamine Function in Posttraumatic Stress Disorder: Emerging Concepts. Washington, DC, American Psychiatric Press, 1996
19. Perry BD, Giller E, Southwick SM: Altered platelet alpha-2 adrenergic binding sites in posttraumatic stress disorder. *In* Giller EL (ed): Biological Assessment and Treatment of Posttraumatic Stress Disorder. Washington, DC, American Psychiatric Press, 1990, pp 87–114
20. Pynoos RS: Traumatic stress and developmental psychopathology in children and adolescents. *In* Oldham M, Tasman A (eds): American Psychiatric Press Review of Psychiatry, vol 12. Washington, DC, American Psychiatric Press, 1993, pp 205–238
21. Pynoos RS, Steinberg AM, Wraith R: A developmental model of childhood traumatic stress. *In* Ciccetti D, Cohen D (eds): Manual of Developmental Psychopathology. New York, John Wiley and Sons, 1994
21a. Robertson J, Robertson J: John, Seventeen Months in Residential Nursery for Nine Days [film]. New York, New York University Film Library, 1969
22. Singer M, Anglin T, Song L, et al: Adolescents' exposure to violence and associated symptoms of psychological trauma. JAMA 273:477–482, 1995

BEST COPY AVAILABLE

25. Southwick SM, Bremner D, Krystal JH, et al: Psychobiologic research in posttraumatic stress disorder. Psychiatr Clin North Am 17:251–264, 1994
24. Taylor L, Zuckerman B, Harik V, et al: Witnessing violence by young children and their mothers. Developmental and Behavioral Pediatrics 15:120–123, 1994
25. Terr L: Childhood traumas: An outline and overview. Am J Psychiatry 148:1:10–20, 1991
26. Thornberry T: Violent Families and Youth Violence. Program of Research and Causes and Correlates of Delinquency. Washington, DC, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, US Department of Justice, 1994
27. True WR, Rise J, Eisen S, et al: A twin study of genetic and environmental contributions to liability for posttraumatic stress disorder. Arch Gen Psychiatry 50:257–264, 1993
28. United States Department of Justice: Crime in the United States. Washington, DC, US Government Printing Office, 1993
29. United States Department of Justice: Crime in the United States. Washington, DC, US Government Printing Office, 1995
30. Yehuda R, Giller EL, Southwick SM, et al: Hypothalamic-pituitary-adrenal dysfunction in PTSD. Biol Psychiatry 30:1031–1048, 1991
31. Yehuda R, Southwick SM, et al: Low urinary excretion in patients with posttraumatic stress disorder. J Nerv Ment Dis 178:366–369, 1990

Address reprint requests to

Steven Marans, PhD
Yale Child Study Center
Yale University School of Medicine
PO Box 207900
230 South Frontage Road
New Haven, Connecticut 06520–7900

e-mail: Steven.Marans@Yale.edu

BEST COPY AVAILABLE

Established 1974, The London Family Court Clinic, Inc.

CENTRE FOR CHILDREN & FAMILIES IN THE JUSTICE SYSTEM

Annual Report 1999

Integrating Research and Practice to Promote Violence Free Communities

Supt. Murray Faulkner
Corporate Services Division
London Police Services
Chairperson
Board of Directors

Peter G. Jaffe, Ph.D.
Executive Director

The London Family Court Clinic was born twenty-five years ago out of a vision by the Honourable Judge Maurice H. Genest with the support of lawyer, Alfred Mamo, and child psychiatrist, Dr. Naomi Rae-Grant. Our name, at conception, matched our function - a clinical service for the Family Court in London, focusing on the needs of 'delinquent' youth.

Since that time, our mandate has expanded in a number of ways, both clinically and geographically. Our clinical work includes not only young offender assessments, but also, child custody disputes, child welfare assessments, child witness court preparation, expert witness testimony, and clinical consultation to residential facilities. Our service has expanded beyond London and the Southwestern Region, Ontario and Canada. Our research and training skills have resulted in collaborative ventures across Canada and the United States, as well as Australia, New Zealand, and parts of Europe.

After twenty-five years, our Board and staff feel that we need a broader name to capture more of our activities. ***"The Centre for Children & Families in the Justice System"*** is that name. To more accurately reflect our overall mission, we have added the phrase, "Integrating research and practice to promote violence-free communities".

Our 1999 Annual Report reflects this broader mandate in the range of activities our staff completed over the past 12 months, as follows:

- 109 (Phase I) (12-15) Referrals under the *Young Offenders Act*
- 24 (Phase II) (16-17) Referrals under the *Young Offenders Act*
- 227 Referrals under the Clinical Supports Program to Custody Facilities
- 53 Referrals for assessment and mediation under the *Children's Law Reform Act.*
- 8 Referrals under the *Child and Family Services Act.*
- 119 Referrals to the Child Witness Project.
- 39 Referrals for Expert Testimony
- 92 Workshops and presentations in 35 communities, 6 provinces, 3 US states, and 2 other countries
- 220 requests for information and publications from across North America and other countries.
- 14 Research grants from 11 funding sources.
- 17 Publications

We feel privileged to work with the calibre of staff, volunteers, and Board members that make our Clinic's achievements possible.

BEST COPY AVAILABLE

Mission Statement

The London Family Court Clinic is a children's mental health centre committed to advocate for the special needs of children and families involved in the justice system. Our advocacy includes assessment, counselling, and prevention services, as well as research and training for the community.

Philosophy and Mandate

The Clinic recognizes that children and families involved in the justice system are in crisis and at a major turning point in their lives. We believe that the justice system has an opportunity to be part of a healing and conflict resolution process when it is responsive to the real needs of children and families. We believe that the Clinic can play a role in making the justice system more sensitive and responsive to children and families. The Clinic plays this role by:

1) providing **clinical assessments** for court, identifying the special needs of children and families in crisis. Children and adolescents are referred to the Clinic by judges and/or lawyers as part of proceedings related to young offenders, custody & access, and child welfare disputes.

2) acting as a bridge between the justice system and helping agencies to match client's needs to appropriate interventions and resources (**service brokerage**).

3) promoting positive adjustment through early **identification** of childhood problems and prevention programs.

4) increasing the knowledge of judges and lawyers, as well as community professionals, about the special needs of children and families involved in the court system (**training and community education**).

5) ensuring that **child victims or witnesses to violence are not revictimized** or further traumatized by court proceedings.

6) conducting applied **research** in collaboration with community partners to make services, policies, and legislation more responsive to the needs of children and families in the justice system.

7) sharing information through **publications and workshops** about innovative Clinic research and programs in Canada.

BEST COPY AVAILABLE

Clinical Services

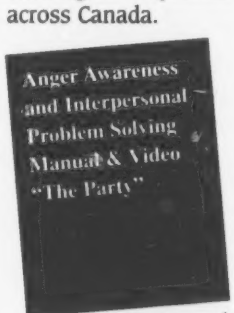
YOUNG OFFENDER SERVICES

A major part of Young Offender Services continues to be assessment. One hundred and nine Phase I (youths 12 and 15 years) and 24 Phase II (youths 16 and 17) reports were completed this year. Broad based, multi-discipline assessments are conducted to provide the court with information about the needs and the risk levels of young offenders with respect to mental health issues, probability of future offending, and community safety. Integral to the assessment process, is the extensive consultation with other service providers to arrange for multi-faceted and multi-level interventions to address the complex needs, risks and issues presented by a seemingly increased number of adolescents.

This year the Clinical Supports Program for youth in custody expanded to embrace service to youth in all residential care facilities in the London area. This collaborative, systems approach ensures the best programming principles of equitable access to service and continuity of care within and between custody and residential settings. Thirteen separate campuses operated by six service providers in the London area participate in this program. We look forward to the results of the external evaluation of the expansion pilot in March of 2000.

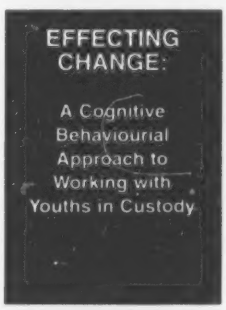
In September 1998, we produced Anger Awareness and Interpersonal Problem Solving: A Group Manual and Video. This cognitive behaviourial and skills-oriented program was funded by the Provincial Young Offenders Trainers, Ministry of Community and Social Services. The development and design of this program addresses the criminogenic needs and characteristics of youth participants, as well as the "realities" of custody settings (e.g. short stays, staff in 24 hour rotating shifts). These resources have been well received and have been distributed to open and secure facilities throughout the province. The training initiative that has supported the effective implementation of this program has involved over 20 workshops with youth justice workers during the year. Approximately 30 training days are scheduled throughout the province in the upcoming year.

Public education, professional training and program development in the area of community based, comprehensive crime prevention strategies continue to be given high priority within this service area and the broader Clinic. In the winter, we traveled to Moosenee and Moose Factory to profile "No to Bullying: Early Intervention for Youth Crime", a joint project with Madame Vanier Children's Services, that was funded for one year by the Ministry of the Solicitor General. In June 1998 we delivered a keynote address at the 13th Atlantic Crime Prevention Conference in Truro, Nova Scotia, and were delighted to share in the exciting developments in this area across Canada.



Anger Awareness and Interpersonal Problem-Solving Manual & Video "The Party"
(Copies available from the Ministry of Community & Social Services – within Ontario; or via the LFCC outside the province)

The Federal Government is poised to enact the *Youth Criminal Justice Act* (YCJA). The impact of this legislation will not be fully understood until we know how the provincial and territorial governments are going to administer justice under the new Act. As we stand on the horizon of the new millennium, it is clear that advocacy, community partnerships, commitment to best programming practices and provision of relevant training, continue to be essential ingredients in the Young Offender team's ongoing efforts to provide assessment and clinical services for youths at risk and to work to make our communities safer.



Effecting Change: A Cognitive Behaviourial Approach to Working with Youths in Custody
(Copies available from the Ministry of Community & Social Services – within Ontario; or via the LFCC outside the province)

CUSTODY & ACCESS PROJECT/MEDIATION SERVICES

During the past year, the Project provided service to 53 families involved in custody and access disputes, and/or mediation services. Referrals for assessment under Section 30 of the *Children's Law Reform Act* were received from lawyers, on behalf of their clients, across Southwestern Ontario, Quebec, the United States, and Europe. The geographical catchment area has increased consistently since the conception of the Project in 1980.

Clinical Services

Parent education on separation and divorce issues is considered a cost-effective means of educating parents and children about the effects of family dissolution. The focus is on providing the understanding and skills to decrease the damage family members often do to each other, especially to the children. Recognizing the need to provide alternative skills to parents to reduce the impact of separation on their children, Project members continue to be involved with IN THE MIDDLE, hosted by Merrymount Children's Centre. The concurrent, but separate, groups participate in one 2 hour session involving play and video for the children to help them normalize their feelings about family separation, video, and discussion to sensitize parents to divorce experiences of children at various developmental stages.

Clinic staff have remained committed to training and research issues related to the complex situations that arise when child custody disputes involve allegations of domestic violence. We have been actively working with two US organizations, **The Family Violence Prevention Fund** and **The National Council of Juvenile & Family Court Judges** in developing training curriculum to better prepare judges, lawyers, and mental health professionals for the many dilemmas that arise.

As well, we have been fortunate in receiving the support of the **Atkinson Charitable Foundation** in developing a research grant on the long-term impact of violence and poverty in the lives of women and children separating from violent partners. This research will examine some of the risk and protective factors that may determine later adjustment in children and adolescents. We have actively consulted with researchers across the United States and Canada in developing this project.

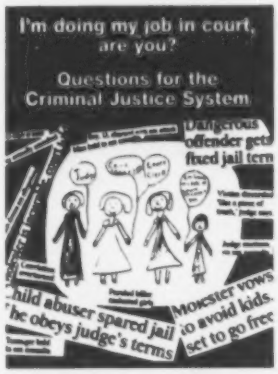
CHILD WITNESS PROJECT

The Child Witness Project has been serving young witnesses in the London and Middlesex area for over ten years. The program was initially set up with the goal of reducing the traumatization of child witnesses in the criminal justice system. First funded by Health Canada as a demonstration study, the Project developed effective techniques for preparing child witnesses to testify in court and established a protocol which is now widely used. Clinical services and research endeavours, as well as training and consultation, have been integral to the Project since its inception.

Cases involving charges of sexual abuse constituted the majority of referrals for the first years of operation; there has been, however, a marked increase in the number of children and youth involved as witnesses in physical abuse and physical assault cases. This year the number of referrals for children who are required to testify in sexual assault and physical assault cases is almost equal. Consistent with referrals of previous years, female children are more highly represented amongst the sexual abuse victims (80%) than they are amongst physical abuse victims (49%).

The Project is also committed to serving children who are witnesses to violent assaults, and, coinciding with the inauguration of the Domestic Violence Court in 1998, we have received a number of referrals of children who are potential witnesses in these matters. Most recently, Project Clinicians have been involved in developing a knowledge base and a preparation protocol for vulnerable adult witnesses with developmental challenges.

The core services of the Child Witness Project include sessions of court preparation with components including a psycho-educational model and stress reduction strategies. The individual child's needs are assessed with respect to their role as witness and an intervention is implemented to meet those needs. Parents and guardians are also involved in this process. Consultation with the crown attorney is provided.



I'm Doing My Job in Court – Are You? Questions for the Criminal Justice System

The Project provides assessments and written reports with respect to competency of a child witness to testify; children's disclosure patterns, sexual abuse issues; credibility and reliability of disclosures; and the use of testimonial aids. During the past year, 48 written reports and 24 assessments were prepared, and expert testimony was provided in 13 cases.

There is a strong research component in the child witness program. In an effort to attain a more complete picture of child witnesses and their experience within the legal system we have developed a new database. In addition to tracking children's

BEST COPY AVAILABLE

Clinical Services

progress through the court system from the time a charge is laid until court outcome, information regarding the nature of the charges laid, child characteristics, and availability of family and other support systems are recorded. The new data system will enable us to examine a larger variety of issues relevant to child witnesses.

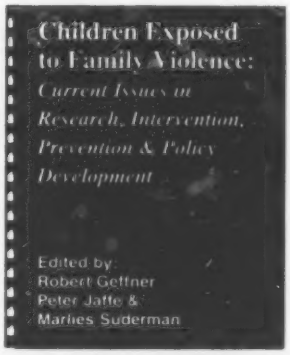
Our most recent research endeavour was a collaborative project with other child witness programs and victim assistance programmes in the province entitled **"I'm doing my job in court: Are you? Questions for the Criminal Justice System**. The study, involving over 900 cases, identified that many children continue to be retraumatized in the Criminal Justice System despite the legislative changes that have been put in place to protect them. Findings indicated that, although some child witnesses fared well, there were significant inconsistencies in the provision of services and in the implementation of the legislative changes. The report contains a number of recommendations that could be quickly and easily be implemented by the Criminal Justice System.

Viva Voce Vol 3 – Issue 1 Summer 1999
(Subscriptions available upon request)

The Local Advisory Board has continued to meet on a regular basis since it first convened in 1988. Represented agencies include the London Police, OPP, Strathroy Police, Crown Attorney Offices in London and St. Thomas; Victim/Witness Assistance Programme, Children's Aid Society of London/Middlesex, and London Family Court Clinic Board members. A recent task of the Board was to apprize the local school boards of the distress experienced by child witnesses when students, on organized school trips, attend at court and listen to the testimony.

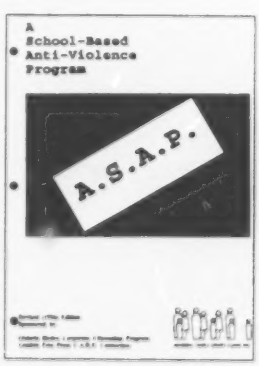
VIOLENCE PREVENTION SERVICES

No to Bullying: Early Intervention for Youth Crime was a project funded this past year by the *Partners Against Crime Program* of the Ministry of the Attorney General and Correctional Services, and undertaken in partnership with *Madame Vanier Children's Services*. The program was aimed at 8 to 11 year old children in grades four to seven, and was carried out in conjunction with schools and community organizations. Goals of the program were to intervene with children who were engaging in bullying behaviours or being victimized, and to implement bullying prevention programs in participating schools and organizations, with a view to reducing bullying and increasing prosocial values and interpersonal skills in all students. Participation of parents, assistance for teachers and administrators, provision of re-educative services to children presenting bullying behaviours (an alternative to suspension program), counselling for students experiencing victimization, and linking families of identified children to services, were features of the "No to Bullying" project.



Proceedings of the 2nd International Conference On Children Exposed to Family Violence held in London, ON, June 1997
(The Clinic regrets the delay in this publication which will be available December 1999 – outstanding orders will be forwarded at that time.)

A.S.A.P.: A School-based Anti-violence Program is a program for primary prevention of woman abuse and violence in relationships. The program is described in the manual of the same name, which was developed and evaluated by the London Family Court Clinic with the support of Health Canada, Family Violence Prevention Division, and the Ontario Hydro Employees Fund. Education initiatives with both elementary and high school students and their schools and communities are at the heart of the program. Ongoing efforts are directed to developing an American version of ASAP with the assistance of the ***Family Violence Prevention Fund***, in California.



A.S.A.P.: A School-based Anti-Violence Program

BEST COPY AVAILABLE

Clinical Services

RESEARCH SERVICES

The Clinic continues to undertake research in areas suggested by our clinical work with families and youths.

Two key projects are now underway that have evolved out of clinical practice. The first is *Access Denied: Poverty and Woman Abuse, the Double Disadvantage*, funded for three years by the **Atkinson Charitable Foundation**. The genesis of this study was an inability to find research that took into account the complex interplay of factors that affect the post-separation well-being of children exposed to family violence. The intent is to investigate the double disadvantage of being both poor and exposed to family violence. We will also explore the risk and protective factors that elevate or reduce the likelihood of negative outcomes for these children.

The second major study, now in its third year, is the *Clinical Trials of Multisystemic Therapy with High-risk Young Offenders*, a collaborative project underway in four parts of Ontario: Ottawa/Carleton, Simcoe County, the Mississauga area, and London/Middlesex. As the second year came to a close, 200 youths and their families were already involved with the project. Initial findings from the evaluation component, indicate that families are reporting significant improvements in functioning and reduced acting-out behaviours of the youths. The next step is to see if these improvements translate into reduced criminal offending in the long-term. Stay tuned!

The Clinic is also approached to undertake projects on a contract basis. In this past year, we conducted an evaluation of Project H.O.P.E., the pre-charge diversion project of the Halton Regional Police Services (1998/99). Their program is well suited to the future directions for youth justice defined in the proposed *Youth Criminal Justice Act*.

In collaboration with the Centre for Research on Violence Against Women and Children, we assisted with a literature review on the topic of vicarious trauma experienced by front-line staff in woman abuse agencies.

In collaboration with the Elizabeth Fry Society of Hamilton, a Violence Awareness Program manual for women was developed to provide guidance to programme deliverers in Ontario correctional facilities. Among the strong messages of the program is that halting the intergenerational transmission of violence is a key benefit to be derived from woman abuse intervention strategies.

Finally, a research direction we see for the future pertains to offending by adolescent women and the effectiveness of justice resources available to them. As a first step in this process, a community meeting was convened where it was agreed that the needs of adolescent women in all service sectors are becoming more challenging. This is an area that we hope to become active in over the next few years.

This cross-pollination of ideas - as clinical practice informs research agendas and research findings advances clinical practice.

EXPERT WITNESS TESTIMONY

The Clinic receives requests from lawyers across Canada to provide assessments on issues that relate to violence and abuse in criminal and civil proceedings. Common issues tend to involve dangerousness of offenders, impact of abuse, and delayed disclosure by victims. In 1998/99 we received 39 referrals.

In July 1998 the Clinic was involved in providing testimony on domestic violence for an inquest called into the 1996 murder-suicide of Arlene May and Randy Iles in the Collingwood area. The jury made over 200 recommendations on how to improve the community and justice response to domestic violence.

The Clinic also served on the Joint Committee on Domestic Violence in 1999, which was a committee of community experts and government officials, to develop a long-term plan to implement the jury recommendations.

BEST COPY AVAILABLE

Board on
Children, Youth,
and Families

BOARD ON CHILDREN, YOUTH, AND FAMILIES

The Board on Children, Youth, and Families was created in 1993, under the joint aegis of the National Research Council and the Institute of Medicine, to serve as the focal point for authoritative, nonpartisan analysis of child and family issues relevant to policy decisions. The Board brings the collective knowledge and analytic tools of the behavioral, social, and health sciences to bear on the development of policies and programs for children, youth, and families. It does so primarily by synthesizing, analyzing, and evaluating relevant scientific research that relates to critical national issues.

Recently completed reports

- Research to Improve Intergroup Relations Among Youth (1999)
- Risks and Opportunities: Synthesis of Studies on Adolescence (1999)
- Adolescent Development and the Biology of Puberty: Summary of a Workshop on New Research (1999)
- Adolescent Decision Making: Implications for Prevention Programs: Summary of a Workshop (1999)
- Revisiting Home Visiting: Summary of a Workshop (1999)
- Evaluating Food Assistance Programs in an Era of Welfare Reform (with the NRC Committee on National Statistics) (1999)
- Children of Immigrants: Health, Adjustment, and Public Assistance (1999)
- Frontiers of Research – The Development of Human Potential in the 21st Century: Opportunities at the Intersection of Families and Communities (1998)
- From Generation to Generation: The Health and Well-Being of Children in Immigrant Families (1998)
- Protecting Youth at Work: Health, Safety, and Development of Working Children and Adolescents in the United States (1998)
- New Findings on Poverty and Child Health and Nutrition: Summary of a Research Briefing (1998)
- Violence in Families: Assessing Prevention and Treatment Programs (1998)
- Educating Language-Minority Children (1998)
- Reducing the Odds: Preventing Perinatal Transmission of HIV in the United States (with the IOM Division of Health Promotion and Disease Prevention) (1998)

- America's Children: Health Insurance and Access to Care (with the IOM Division of Health Care Services) (1998)
- Systems of Accountability: Implementing Children's Health Insurance Programs (with the IOM Division of Health Care Services) (1998)
- Longitudinal Surveys of Children: Report of a Workshop (with the NRC Committee on National Statistics) (1998)
- Improving Schooling for Language-Minority Children: A Research Agenda (1997)

Studies in progress or under development

- Integrating the Science of Early Childhood Development
- Juvenile Crime: Prevention, Intervention, and Control
- Training Health Care Providers to Recognize and Refer Family Violence
- Frameworks for Designing and Evaluating Community-Level Programs for Youth
- Tools and Strategies for Protecting Children on the Internet
- A Study on Youth Violence in Schools

Recent and anticipated workshops

- Early Childhood Interventions
- Workshop on Early Precursors of Antisocial Behavior
- Children in Out of Home Placement
- Child Care Performance Measures
- Sleep Needs, Patterns, and Disorders of Adolescents
- Promoting Child and Adolescent Development During the After School Hours
- The Role of Parents in Promoting Adolescent Development, Health, and Well-Being
- Regional Journalist Seminar – Kansas and Missouri

Topics under consideration for future work

- Reducing Disparities in the Health Status of Children
- Preventing Motor Vehicle Accidents Among Adolescents
- Childhood Disabilities
- Attention Deficit and Hyperactive Disorder Among Children
- Respect for Diversity: Promoting Peaceful, Respectful Relations Among Youth
- Ethical, Social, and Legal Issues Regarding Clinical Research with Children (with the Board on Health Sciences Policy)
- Social, Legal, and Ethical Issues Related to Genetic Testing
- Effectiveness of Contraception Among Teens

Members of the Board on Children, Youth, and Families

Jack P. Shonkoff (*Chair*), Heller Graduate School, Brandeis University
Evan Charney (*Co-Chair*), University of Massachusetts
James Banks, Center for Multicultural Education, University of Washington
Sheila Burke, John F. Kennedy School of Government, Harvard University
David Card, Department of Economics, University of California, Berkeley
Donald Cohen, Chief, Child Psychiatry, Yale University
Mindy Fullilove, Columbia University
Kevin Grumbach, Department of Family and Community Medicine, Primary Care Research Center, University of California, San Francisco
Maxine Hayes, University of Washington School of Medicine
Margaret Heagarty, Department of Pediatrics, Harlem Hospital Center, Columbia University
Reneé Jenkins, Department of Pediatrics and Child Health, Howard University Hospital
Sheila Kamerman, School of Social Work, Columbia University
Harriet Kitzman, School of Nursing, University of Rochester
Sanders Korenman, School of Public Affairs, Baruch College, City University of New York
Honorable Cindy Lederman, Circuit Court Judge, Juvenile Justice Center, Dade County, Florida
Sara McLanahan, Office of Population Research, Princeton University
Vonnie McLoyd, Center for Human Growth and Development, University of Michigan
Paul Newacheck, Institute of Health Policy Studies and Department of Pediatrics, University of California, San Francisco
Gary Sandefur, Department of Sociology, University of Wisconsin- Madison
Elizabeth Spelke, Massachusetts Institute of Technology
Ruth Stein, Albert Einstein College of Medicine
Paul Wise, Department of Pediatrics, Boston Medical Center

Ruth T. Gross (*Liaison*), Board on Health Promotion and Disease Prevention, Institute of Medicine
Eleanor Maccoby (*Liaison*), Commission on Behavioral and Social Sciences and Education, National Research Council
William Roper (*Liaison*), Institute of Medicine Council

Members of the Forum on Adolescence

David Hamburg (*Chair*), President Emeritus, Carnegie Corporation of New York
Huda Akil, Mental Health Research Institute, University of Michigan
Cheryl Alexander, School of Hygiene and Public Health, Johns Hopkins University
Claire Brindis, Institute for Health Policy Studies and Division of Adolescent Medicine, University of California, San Francisco
Camille Zubrinsky Charles, Department of Sociology, University of Pennsylvania
Greg Duncan, Institute for Policy Research, Northwestern University
Jacquelynne Eccles, School of Education, University of Michigan

Abigail English, Adolescent Health Care Project, National Center for Youth Law, Chapel Hill, North Carolina
Eugene Garcia, School of Education, University of California, Berkeley
Helene Kaplan, Skadden, Arps, Slate, Meagher, and Flom, New York City
Iris F. Litt, Division of Adolescent Medicine, Stanford University
John Merrow, The Merrow Report, New York City
Anne Petersen, W.K. Kellogg Foundation, Battle Creek, Michigan
Karen Pittman, International Youth Foundation, Baltimore, Maryland
Anne Pusey, Jane Goodall Institute's Center, University of Minnesota
Michael Rutter, Institute of Psychiatry, University of London
Stephen Small, Department of Child and Family Studies, University of Wisconsin, Madison
Beverly Daniel Tatum, Mount Holyoke College

Baruch Fischhoff (*Liaison*), Social and Decision Sciences, Carnegie Mellon University
Ruth T. Gross (*Liaison*), Board on Children, Youth, and Families
Eleanor E. Maccoby (*Liaison*), Department of Psychology (emeritus), Stanford University

Board and Forum Staff

Michele Kipke, Director, Board on Children, Youth, and Families and Forum on Adolescence, 202-334-3883, mkipke@nas.edu
Deborah Phillips, Study Director, Committee on Integrating the Science of Early Childhood Development, 202-334-1936, dphillip@nas.edu
Nancy Crowell, Study Director, Panel on Juvenile Crime: Prevention, Treatment, and Control, 202-334-1373, ncrowell@nas.edu
Mary Graham, Associate Director, Dissemination and Communications, 202-334-2998, mgraham@nas.edu
Jennifer Gootman, Study Director, Committee on Community-Level Programs for Youth, 202-334-1937, jgootman@nas.edu
Felicia Cohn, Study Director, Committee on the Training Needs of Health Professionals to Respond to Family Violence, 202-334-1414, fcohn@nas.edu
Nancy Geyelin Margie, Research Assistant, Committee on Integrating the Science of Early Childhood Development, 202-334-1349, nmargie@nas.edu
Mary Strigari, Administrative Associate, 202-334-1935, mstrigar@nas.edu
Drusilla Barnes, Senior Project Assistant, Committee on Community-Level Programs for Youth, 202/334-2034, dbarnes@nas.edu
Amy Gawad, Senior Project Assistant, Forum on Adolescence, 202-334-1937, agawad@nas.edu
Ronné Wingate, Project Assistant, Committee on Integrating the Science of Early Childhood Development, 202-334-1396, rwingate@nas.edu
Michael Rosst, Project Assistant, Communications and Dissemination, 202-334-1952, mrosst@nas.edu

Scholar-in-Residence

Elena Nightingale, 202-334-3882, enightin@nas.edu

updated 1/00

Board on Children, Youth, and Families

Forum on Adolescence

Spring 2000

A newsletter of the Forum on Adolescence, a program unit of the Board on Children, Youth, and Families, National Research Council and Institute of Medicine of the National Academies

The Forum on Adolescence Comes of Age

Adolescence is a time of tremendous potential and considerable risk, when fundamental needs must be met to assure healthy, constructive, and rewarding adult lives; inattention to these needs imperils not only a generation but the basic fabric of society. The contributions that authoritative, non-partisan analysis and synthesis of research and policy could make on issues related to children and families led the National Academy of Sciences to establish the Board on Children, Youth, and Families under the auspices of the National Research Council and Institute of Medicine in 1993. As the body of research on adolescence has grown, the value of a specific focus on adolescent research and policy led to the development of the Forum on Adolescence as a program of the Board in 1996.

Focus on Adolescents is the first in a series of updates on the Forum's work for individuals, agencies, and institutions that are concerned with critical policy and research issues related to adolescent health and development. *Focus on Adolescents* is also available online and in print form.

About the Board and Forum

As with other programs of the National Academies, the Board on Children, Youth, and Families oversees a broad range of activities including major studies, workshops, and policy briefings that inform the nation's decision makers, research community, and general public on pivotal issues related to children, youth, and families. The Board's primary goal is to help inform policy and practice through a comprehensive review of the best available research. Board and Forum members—nationally recognized experts in a variety of disciplines, including child and adolescent development, pediatrics, sociology, education, public policy, law, and public health—volunteer their time to study substantive and emerging concerns. Members analyze, synthesize, and evaluate available scientific research, identifying gaps and providing recommendations for further study and policy development. Projects are often undertaken at the request of Congress and government agencies or private foundations, although many project ideas are initiated within the Forum.

Michele D. Kipke, Director of the Board and Forum, and staff convene bi-annual planning meetings for both Board and Forum members, coordinate major studies, and organize specific workshops, such as a series of sessions on placement of children in the child welfare system. The Board often collaborates with other National Academies' entities: an ongoing study of juvenile crime prevention, treatment, and control, for example, is being carried out with the National Research Council's Committee on Law and Justice. When program areas focus on broader issues related to adolescents, the Forum on Adolescence spearheads the initiative.

The National Academy of Sciences was established in 1863 to advise Congress on issues related to science and policy. Together with its operating arm—the National Research Council—the National Academy of Engineering and the Institute of Medicine comprise the National Academies which inform the government on science, technology, and medicine, providing authoritative, independent recommendations and policy advice.

Forum History, Mission, and Goals

As the work of Carnegie Corporation of New York's Council on Adolescent Development drew to a close in 1995, then-president David Hamburg sought to establish several key activities to carry on the Council's mandate of providing a forum for synthesizing and generating the best available knowledge and wisdom about adolescence in America. Based on his experience as president of the Institute of Medicine, he viewed the Board on Children, Youth, and Families as a dynamic environment for continued growth and development of this work.

Michele Kipke, a health psychologist, became Forum Director in the summer of 1997. In 1998, Michele also assumed the role of Board Director. The Forum's primary mission was defined: to synthesize, analyze, and evaluate research on critical national issues related to youth and families, providing a broad-based analysis of policy and program implications. Specific goals include:

• reviewing, synthesizing, and analyzing the science base on adolescent health and development;

• identifying new directions and support for relevant research;

• showcasing new research, policies, and programs with the potential to improve adolescent health and well-being;

• promoting leadership on adolescent research and policy by fostering collaboration among individuals with diverse perspectives and backgrounds; and

• disseminating research on adolescence and related policy implications to a wide variety of interested groups, including decision makers, researchers, and the general public.

Program Themes and Activities to Date

Forum initiatives are guided by a 21-member standing body with expertise in adolescent development who represent a range of disciplines in the behavioral, social, and health sciences (see box on back page). At its first two meetings, the Forum identified several overarching themes and activities designed to provide tangible and innovative approaches addressing each of these issue areas. The themes, and the activities stemming from each, are as follows:

Understanding and Promoting Healthy Adolescent Development

The Forum will conduct activities that will bring state of the art scientific expertise to bear on our understanding of the health, development, and well-being of adolescents and young adults, both in the United States and worldwide.

• One of the Forum's first activities was a workshop on Adolescent Development and the Biology of Puberty held in March 1998. The meeting brought together an interdisciplinary group of researchers with backgrounds in behavioral genetics, physiology, endocrinology, neurology/psychiatry, psychology, other fields to assess new research related to adolescent development, to discuss policy and program implications, and to identify future research needs. A summary report from this workshop is currently available.

• A workshop on Sleep Needs, Patterns, and Difficulties of Adolescents was convened on September 22, 1999 to explore research and policy issues related to adolescent sleep needs and problems. Although research is limited, sleep problems are associated with an increased risk of morbidity and mortality and represent an important public health concern for adolescents. A summary report will be available in summer 2000.

• The Board and Forum have launched an 18-month study, Frameworks for Designing and Evaluating Community-Level Programs for Youth. A committee has been established to review and synthesize available data on community interventions and programs to promote positive outcomes for adolescent development. The committee met for the first time on October 7-8,1999.

The committee's first workshop, held on October 21, 1999, examined research on the developmental needs of children and adolescents, ages 5 to 14 years, and the ways in which they spend their time after school. Promoting Child and Adolescent Development During After School Hours examined the types of after school programs that have been developed for children and teenagers, with attention to program structures, implementation issues, desired outcomes, and evaluation methodologies. The policy implications of this research were also explored.

The second, entitled the Workshop on the Science of Youth Development Programs, brought together teachers, researchers, service providers, policy

BEST COPY AVAILABLE

makers, and other key stakeholders to examine research and "lessons learned" from developing, implementing, and evaluating youth development intervention programs. This workshop was held on January 31, 2000. Audio of the workshop is available on the Board's website.

Race, Ethnicity, and Cultural Diversity Among Adolescents

The size, mean age, and racial and ethnic composition of the adolescent population has changed dramatically during the past few decades, and these changes will continue well into the 21st century. As we enter the new century, more adolescents than ever before will be part of the population. Moreover, a significant shift in the racial and ethnic composition of the nation is currently taking place.

• In response to major changes in the ethnic composition and age distribution in the population, the Forum convened workshop on Research to Promote Intergroup Relations among Youth. The meeting showcased research designed to promote intergroup relations among ethnically diverse youth. Participants reviewed the knowledge base on the effectiveness of school-based interventions to promote respect and prevent intergroup conflict and violence. The workshop was the first in a series, and a summary report was published in December 1999.

• The Forum plans to launch a major initiative on Promoting Peaceful, Respectful Relations Among Youth. Information about the initiative will be posted on the Forum and Board's webpage at: national-academies.org/cbsse/bocyf

The Family Environments of Adolescents

Compared to research on families with young children, there has been relatively little focus or attention to the home and family environments of adolescents. Yet it is clear that adolescents develop best when they grow and develop within supportive home and family environments.

• The Forum is planning a workshop later this year, entitled The Role of Parents in Promoting Adolescent Development, Health, and Well-Being. Workshop participants will review the knowledge base regarding the role of parents, families, and other caretakers in promoting adolescent development, health, safety, and well-being. The workshop will plan activities to inform future work in this area.

Policies and Institutions Intended to Support Adolescents and Their Families

Social institutions, including education, child welfare, and the health care delivery system, can play an important role in ensuring the healthy development of children and adolescents.

• In collaboration with the Board, the Forum convened a workshop on the experiences of Children in Out-of-Home Placement in July 1999 to examine available data on the characteristics of children, youth, and families who are at risk in out-of-home placements. Participants reviewed the quality of current indicators and measures and identified the gaps in the knowledge base related to the health and well-being of children, youth, and families involved with the child welfare system. A workshop report will be available in spring 2000.

All Forum meetings are open to the public. Forum reports are available online and through the National Academy Press, and summaries will be distributed via an electronic newsletter to interested persons. Forum members and staff welcome comments and feedback from policy makers, researchers, the youth services community, and the general public. Please contact us at national-academies.org/cbsse/bocyf

Funding for the Forum

Core funding for Forum initiatives and activities is provided by the Carnegie Corporation of New York. Funders of Forum project activities include the W.T. Grant Foundation, the Ford Foundation, the David and Lucile Packard Foundation, and the National Institutes of Health, the Office of the Assistant Secretary of Planning and Evaluation, and the Maternal and Child Health Bureau of the U.S. Department of Health and Human Services.

BEST COPY AVAILABLE

Current and Forthcoming Reports

Research to Promote Intergroup Relations Among Youth Summary of a workshop held in November 1998 to review the knowledge base on the effectiveness of interventions to promote intergroup relations among youth. Fall 1999.

Risks and Opportunities: Synthesis of Studies on Adolescence. Synthesis and summary of major issues, themes and policy implications of adolescent-related issues, based on a review of more than 60 reports published by the National Academy Press. Fall 1999.

Sleep Needs, Patterns, and Difficulties of Adolescents. Summary of a workshop held in fall 1999 to discuss the health and policy implications of research on the subject. Available summer 2000.

Children in Out-of-Home Placement. Summary of a workshop held in summer 1999 to review the issues surrounding health and well-being of children and families involved in the child welfare system. Available summer 2000.

Opportunities to Promote Child and Adolescent Development in the After School Hours. Summary of a workshop held in October 1999 to examine research on the developmental needs of children and teenagers and the types of after school programs designed to promote the health and development of these young people. Available summer 2000.

Register for Upcoming Workshops and Meetings

Regional Journalists' Seminar - Kansas City, Missouri, April 11-12, 2000

The Role of Parents in Promoting Adolescent Development, Health, and Well-Being, Spring 2000 (Tentative)

Members

David Hamburg (chair), President Emeritus, Carnegie Corporation of New York

Huda Akil, Mental Health Research Institute, University of Michigan

Cheryl Alexander, Center for Adolescent Health, Johns Hopkins University

Claire D. Brindis, Institute for Health Policy Studies, University of California, San Francisco

Camille Zubrinsky Charles, Department of Sociology, Ohio State University

Greg Duncan, Institute for Policy Research, Northwestern University

Jacquelynne Eccles, Institute for Social Research, University of Michigan

Abigail English, Adolescent Health Care Project, National Center for Youth Law, Chapel Hill, NC

Eugene Garcia, Graduate School of Education, University of California, Berkeley

Helene Kaplan, Skadden, Arps, Slate, Meagher & Flom, LLP, New York

Iris F. Litt, Division of Adolescent Medicine, Stanford University School of Medicine

John Merrow, The Merrow Report, New York

Anne C. Petersen, W.K. Kellogg Foundation, Battle Creek, MI

Karen Pittman, International Youth Foundation, Baltimore, MD

Anne Pusey, Department of Ecology, Evolution, and Behavior, University of Minnesota

Michael Rutter, Institute of Psychiatry, University of London

Stephen A. Small, Department of Child and Family Studies, University of Wisconsin, Madison

Baruch Fischhoff (liaison), Social and Decision Sciences, Carnegie Mellon University

Reneé Jenkins (liaison), Department of Pediatrics and Child Health, Howard University Hospital

Eleanor E. Maccoby (liaison), Department of Psychology (Emeritus), Stanford University

Advisor

Elena Nightingale, Scholar in Residence, Board on Children, Youth, and Families

For information on upcoming activities and future projects under consideration, contact:

Michele Kipke, Director, at 202-334-1937 or mkipke@nas.edu
Mary Graham, Associate Director, Dissemination and Communications, at 202-334-2998 or mgraham@nas.edu
Amy Gawad, Senior Project Assistant, at 202-334-1937 or agawad@nas.edu

Visit our webpage for information on upcoming meetings and to download summaries and reports: **national-academies.org/cbsse/bocyf**